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AUTHOR Cramer, David; And Others
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ABSTRACT

This document consists of the second section of a book written to educate and inform those in the helping professions on how to deal with Acquired Immune Deficiency Syndrome (AIDS). The five chapters in section 2 focus on diversity, each dealing with a special population with its own needs and a unique way of handling issues associated with AIDS. "The HIV-Positive Individual" (David Cramer) addresses the issues of the human immunodeficiency virus (HIV) positive individual, spotlighting the various stages a seropositive person goes through as he or she changes from being asymptomatic to symptomatic. "The Forgotten Seven Percent: Women and AIDS" (Margaret Nichols) combines the issues of AIDS with the issues of being a woman. "Special Needs of Today's Adolescents" (Barbara Slater) addresses issues of adolescence, examining the thinking, beliefs, and knowledge of adolescents and how counselors can assist them in coping with their fears and confusion over AIDS. "Double Indemnity: Substance Use and AIDS" (Ted Knapp-Duncan and Grant Knapp-Duncan) elaborates on the specific issues that substance users face in this time of AIDS, examining both intravenous drug users on the street and "white collar" drug users. "Culturally Sensitive AIDS Counseling" (Sally Jue and Craig Kain) is both content-oriented, looking at ways cultures view AIDS, and process-oriented, presenting ways in which counselors can be more attuned to the issues of particular groups not in the mainstream of society. (NB)

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Section Two

WORKING WITH SPECIFIC POPULATIONS

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Section Introduction

On August 10, 1987, *Newsweek* magazine ran a lead article entitled "The Face of AIDS." The magazine's cover was plastered with pictures of men and women, young and old. The purpose of the article was to remind the magazine's readers of the people behind the Centers for Disease Control statistics. In a similar vein, this section focuses on the lives of the people imprisoned by the crisis. It covers issues that arise when a counselor works with the diverse populations of people with HIV infections.

Diversity is the key to this section. Each chapter focuses on a specific population with its own needs and a unique way of dealing with the issues of AIDS. Leading this section is a chapter by Cramer that envelops the broadest ground. In chapter 3, Cramer addresses the issues of the HIV-positive individual, spotlighting the various stages a seropositive person goes through as he or she changes from being asymptomatic to symptomatic.

The other four chapters in this section describe the plight of specific subpopulations of the larger group of HIV-infected individuals. In chapter 4 Nichols combines the issues of AIDS with the issues of being a woman in today's society. Nichols writes that "it is important for counselors to be aware that HIV-infected women are, of all persons with AIDS, perhaps the most isolated, least supported, and least cohesive group." Throughout her chapter she provides counselors with ways to address issues specific to women.

Adolescence is characterized by the need to explore and the belief in personal invulnerability. In light of what health care professionals know about the transmission of AIDS, this combination proves deadly. Slater, in chapter 5, addresses issues of adolescence, examining the thinking, beliefs, and knowledge of adolescents and how counselors can assist them in coping

with their fears and confusion over AIDS. Like women with AIDS, adolescents with AIDS face many issues unique to them that also are addressed in this chapter.

Substance use and abuse still remains one of the major vectors for the HIV virus. Ted Knapp-Duncan and Grant Knapp-Duncan elaborate on the specific issues that substance users face in this time of AIDS. Chapter 6 examines not only the intravenous drug users on the street but also the "white collar" drug user. The authors pay particular attention to the difficult situation that counselors face as they work with clients contending with both failing health and a chemical dependency.

Within the groups previously mentioned (HIV seropositive, women, adolescents, and drug users), not every person with AIDS is a White, middle-class American. The HIV does not discriminate; it infects members of ethnic minority groups at a rate disproportionately greater than the minorities' representation in the general population. Jue and Kam examine issues specific to culturally sensitive counseling. Chapter 7 is both content-oriented, looking at the ways specific cultures view AIDS, and process-oriented, presenting ways in which counselors can be more attuned to the issues of particular groups not in the mainstream of society.

Although the chapters in this section describe the myriad issues important to the specific subgroups of the larger population of HIV-infected people, there is a unifying theme repeated throughout the chapters of this section. In all cases, whether working with someone symptomatic or asymptomatic, old or young, man or woman, drug abuser or recovering alcoholic, White, Black, Asian, Hispanic, or Native American, it is important that counselors remember that people with AIDS are, first and foremost, people.

Chapter 3

THE HIV-POSITIVE INDIVIDUAL

David Cramer

The AIDS epidemic has directly touched the lives of millions of people around the world. Most noticeable is the tragedy individuals afflicted with the more serious disorders experience during the advanced stages of the infection. Less visible, however, are one to two million estimated Americans who are HIV (human immunodeficiency virus) seropositive and who are asymptomatic; that is, they display no outward indications of infection. The asymptomatic individual will struggle with many of the same issues as the individual with full-blown AIDS: discrimination, death and dying, health concerns, rejection by loved ones, and, in most cases, coming out as a gay man or an IV drug user. With wider availability of anonymous testing sites, larger numbers of people are opting to receive testing in order to prepare for their future. This can result in more individuals who will seek counseling in an effort to determine if they should be tested or as an outcome of learning they are HIV-positive. This chapter will focus on the various stages of HIV-positive seroconversion in which counseling may be beneficial: pre- and posttesting for HIV antibody status, ongoing medical care, and ongoing psychotherapy with its attendant clinical issues.

Pretest Counseling

People may consider taking the HIV antibody test for various reasons. Some may believe they have been exposed to the virus due to past behaviors, which may or may not have been

highly risky. For example, a fear of infection sometimes stems from a sense of punitive guilt for engaging in extramarital behavior rather than from having engaged in sexual acts thought to spread the virus. The counselor, therefore, will need to have a sound knowledge base about AIDS and how the virus is spread in order to adequately help people make decisions about testing. In addition, the differences between anonymous testing sites and confidential tests should be highlighted, so that the individual considering testing can opt for the site that offers him or her a balance between protection from discrimination and sound ongoing medical treatment. If the individual simply desires the test results for personal knowledge, then the anonymous sites offer more protection from potential discrimination. If the desire to be tested stems from strong medical concerns, and the client has a supportive ongoing medical doctor, then confidential testing as a part of a medical regimen may be preferred in order to enhance diagnosis and treatment.

The importance of sound and comprehensive counseling as a component of HIV antibody testing is based on the findings that HIV antibody testing is often followed by increased emotional distress, increased substance abuse, and vocational disruption (Coates, Morin, & McKusick, 1987a). The same authors, in a different report (Coates, Morin, & McKusick, 1987b) noted that most seropositive individuals experience anxiety, depression, insomnia, and memory problems after learning their status. In addition, suicidal thought, guilt, withdrawal, and feelings of hopelessness were commonly reported aftereffects. Therefore, it is important to keep in mind that the decision to be tested can have powerful emotional consequences. Counseling is important in providing each individual with the capabilities and resources for dealing with the behavioral and psychological results of testing.

Perry and Markowitz (1988) outlined five important components of pretest counseling: What the test actually means, confidentiality, the decision to be tested, assessing the client's strengths and weaknesses, and responding to the client's questions. The counselor who is working with clients who are considering HIV antibody testing should become familiar with each of these elements.

Clinical Measurement: What the Test Means

The two procedures most often utilized are the ELISA (enzyme-linked immunosorbent assay) and the Western Blot.

Both of these tests are conducted on a specimen of blood taken from the individual, and there is a delay of several days to 2 weeks before the lab results return. Tests that can produce more immediate results are being developed. It is important to note that these are not tests for AIDS, but tests that determine if the individual has developed antibodies to HIV, a sign that he or she has been exposed to the virus and may be infectious—capable of spreading the virus to others. The ELISA, which is the quickest and least expensive of the two measures, is usually followed by the Western Blot as a confirmatory test if the ELISA is positive. The combination of the two tests results in an accurate protocol, where the chances of a false positive result (obtaining a positive result in an individual who is not infected) are slim. However, as it may take 6 to 12 weeks or more for an individual to develop antibodies after an infection, a person who is tested during this period between infection and the development of a measurable immune response might receive a false negative (a report stating that he or she is not infected when indeed they are). Therefore, anyone who has engaged in high-risk behaviors will require repeat testing at 2-month intervals to confirm they are not infected with HIV. When an individual first tests positive, he or she is said to have seroconverted from seronegativity to seropositivity.

The pretest counseling period is the appropriate time to discuss prognosis with clients, when they are not overwhelmed with learning they are positive, or so relieved at learning they are negative that they fail to pay close attention to the counselor. The discussion of prognosis should address the fact that most people who are seropositive do not have AIDS and will not develop it in the near future. Estimates are that only 1% of the 1.5 million people thought to be HIV-positive have developed AIDS. In one study, Hessol et al. (1987) reported that 4% to 5% of HIV-positive individuals will develop AIDS each year following the initial infection. In addition, with faster intervention and new experimental drugs, an informed HIV-positive individual today will fare better medically than one who developed the infection early on in the epidemic.

Confidentiality Versus Anonymity

A discussion of confidentiality requires the counselor to be well versed about local laws pertaining to mental health privacy

and discrimination related to AIDS. Present thinking on this matter is mixed, and when a counselor should consider breaching confidentiality will be discussed later in this chapter.

Counselors should be aware that medical records are confidential in much the same manner as are mental health records. This means that, with written consent from the client, outside agencies such as insurance companies can obtain these records. Thus any testing performed in a physician's office or clinic will be incorporated in the client's medical records. This can be distinguished from the anonymous testing sites, which have been established in major cities throughout the country. Anonymous sites were created to encourage individuals to seek testing and counseling without any risk that their results would become part of a medical record. When an individual contacts such a site and makes an appointment for testing, he or she is asked to give a false name or is assigned a randomly generated code number. No information is obtained that could identify the individual. The individual's privacy is thereby closely guarded.

Making the Decision

The decision to be tested is a complex process. The Centers for Disease Control (CDC) (CDC, 1987a) have proposed that people in the following categories undergo testing: men who have engaged in homosexual behavior since 1978; IV drug users; recipients of blood and blood products between 1978 and March 1985; sexual partners of any of the preceding; women from any of the preceding groups considering pregnancy; people treated for sexually transmitted diseases; patients treated for medical, psychiatric, or neurological illnesses that may be caused by HIV infection; people who have multiple sex partners; individuals who continue to engage in high-risk behaviors; and emigrants from countries where HIV infection is high. In another report, the CDC (1987b) estimated that 20%–25% of exclusively gay men are seropositive, with that figure rising as high as 68% in some locales. Sixty-five percent of people with hemophilia are thought to be seropositive, and approximately 5% of all IV drug users may be infected with HIV (in New York City it is estimated that 50%–65% of IV drug users are seropositive). The important decision to be tested can best be made after careful thought has been given to exploring the need to know. Some individuals with minimal risk (such as

someone who had a blood transfusion in an area of the country not heavily affected by the epidemic) may have a strong and pressing desire to know and may be obsessed with the fear of not knowing. Another individual who has engaged in risky behavior over a long period of time may choose to adapt to a safe life style and act "as if" they are seropositive, without seeking verification. Deciding to be tested means that one must admit to oneself to having engaged in risky behavior, and one must also then deal with the fear, worry, and anxiety associated with this admission. Clients can best explore these issues in a setting where they feel safe and secure about the privacy of their counseling.

Assessing Strengths and Weaknesses

Another factor that requires discussion before testing is the individual's particular strengths and vulnerabilities that will play a role in how the person copes with the test results. The counselor should explore how the client would react to a positive or negative test result, how the client has reacted to stressful events in the past, in whom the client would confide or to whom disclose the results, and whom they would perceive to be sources of support. Does the client have an adequate support network? Does the client have negative feelings about him- or herself to the degree that a positive test result might be catastrophic? Why is the client seeking testing at this particular time? These are all valid questions for exploring the client's motivations and inner capacity for handling stress. It is important that the counselor familiarize the client with resources in the community that can provide ongoing care in the areas a client is likely to feel vulnerable.

Answering Questions

The last phase of pretest counseling involves encouraging the client to ask questions or raise any concerns that still exist. Perry and Markowitz (1988) also suggested that the client be told that the posttest session will include his or her test results and information about resources in the community. The client is then instructed to refrain from engaging in any sex or needle sharing until that session. At that time, the client can be given

detailed information about how to prevent the spread of HIV, as the client will most likely be highly motivated to attend to this material once he or she knows the test results.

Posttest Counseling

The posttest counseling session can be lengthy and require well over an hour to properly help a person begin integrating the results of his or her HIV status. The session should begin with a clear statement that the client's results indicate that he or she is HIV-infected or not infected. Following this notification, it may be helpful to again outline what the test results mean and delineate the limitations of the status (i.e., it is not a test for AIDS). The immediate needs of the seropositive individual will require attention. Perry and Markowitz (1988) suggested that up to 20 minutes be given to allow the seroconverted individual time to cope with the probable initial numbness and disbelief, and any feelings of anger, fear, or despair. The counselor may need to take an active and direct stance in exploring these reactions, as even clients who had previously stated they believed they would test positive will have emotional reactions to the confirmation. It is best to begin the work of resolving these feelings immediately, because the longer they go unaddressed the more likely that maladaptive denial will be utilized to cope with the distress. A positive test result means the individual will have to struggle with life-and-death issues for the rest of his or her life, cope with uncertain and painful medical treatments, and deal with constant discrimination and rejection. Those clients who test seronegative will also require time to discuss their doubts about the test's validity and the fact that a negative result is not a protection against future infection.

The next phase of the posttest session involves a detailed discussion of how to prevent the spread of HIV. This can give the HIV-positive individual a sense of control that can counter feelings of helplessness that are often associated with this infection. This also encourages the client to act responsibly, which can result in reducing any guilt he or she may feel about past behaviors that may have spread the virus. The seronegative individual will probably be highly motivated at this point to learn the difference between risky and safer behaviors. This information should be presented clearly and directly, with the

counselor making certain that the client understands the proper use of condoms, how to clean needles, and so forth. This is not a time for taking shortcuts, and the client should be engaged in a discussion of what he or she needs to alter and what problems might interfere with adopting healthy and safe behaviors. A list of resources and pamphlets that outline the above information should be given to the client.

The final consideration of posttest counseling involves assessing follow-up needs. It is important to encourage the client to maintain sound ongoing medical contact, and a solid nutritional and exercise program. The counselor should also assess the client's tendency toward self-destructive behavior. Is the seropositive individual likely to abuse alcohol or drugs as a means of coping with test results? Is the seronegative individual unable to stop from engaging in compulsive, unsafe sexual behavior? The session should be ended in a manner that encourages continuity of care and expresses confidence in the client's ability to prevent the spread of HIV.

Counseling efforts in conjunction with testing programs need to offer the HIV-positive individual immediate support and reassurance that a positive report is not a death sentence. Both pretest and posttest counseling should stress that the test is not a diagnosis of AIDS. Learning that one has a positive conversion can produce a shock-like state, and for some clients, the posttest counseling will need to help them through the resultant crisis situation. Many individuals will enter the testing protocol fully expecting a positive outcome based on their past sexual or drug usage history. For most people, however, some degree of trauma is to be expected as a result of learning such news. It is vital that those who test positive be encouraged to follow sound medical advice and a solid nutritional program and be given a list of resources they can contact in the future for financial and emotional support.

Counseling for Health Care Workers

Magallon (1987) described the necessary counseling strategies that compliment ongoing medical treatment. Her suggestions, targeted toward physicians and health care professionals, emphasize providing reassurance, education, and instruction to the HIV-positive client. Reassurance includes confirming the

individual's right to privacy and confidentiality. Such guarantees can further ensure that the client will continue with regular medical treatment, which can aid in maintaining good health. Education about the virus reduces unnecessary fear and can empower the individual in making life choices. Examples of this include educating HIV-positive women about pregnancy, and educating all HIV-positive clients about safer sexual practices. Providing instruction to the client centers around prescribing behaviors that can help maintain or improve the client's physical well-being. This includes following a nutritionally sound diet that offers adequate caloric intake, engaging in a rigorous exercise program, avoiding of the use of drugs and alcohol, getting proper rest, maintaining good hygiene, and reducing stress and anxiety. All of these components are important to supporting an efficient immune system.

Counseling and Psychotherapy

The above information forms the basis for sound adjunctive counseling to testing programs and medical care. Most individuals will probably find this level of information and support sufficient in enabling them to continue to lead productive lives. However, an increasingly large percentage of HIV-positive individuals are likely to seek out ongoing counseling and psychotherapy as a means of obtaining more control over their health and making life-style decisions or because of incapacitating depression. For some, short-term treatment oriented toward introducing stress management skills, reducing anxiety and fears, and alleviating mild depression will be sufficient. However, counselors need to be prepared to provide services to individuals seeking long-term therapy, whether they were already in treatment before being tested, or whether they seek therapy as an aftermath of their test results. In addition, because the AIDS virus has affected all segments of our population, the counselor needs to be aware of ethnic and cultural factors, as well as be sensitive to factors associated with how the individual became infected. A middle-class gay man will probably have different treatment needs than the girlfriend of an IV drug user. The following guidelines are general suggestions for the counselor who is working with a client with HIV infection.

Coping With Stress

Every person has one's own individualistic manner of responding to stress. Some clients will face the stress-producing event (learning one is HIV-positive) directly and begin to make dramatic life-style changes in order to help maintain optimal functioning of their immune system. Other clients may utilize the defense mechanism of denial as a major coping strategy. Still others may experience tremendous guilt, depression, and entertain suicidal thoughts. Almost all will have to find ways of coping with enormous amounts of stress. Most likely to occur is an increase in reliance on an individual's normal defense mechanism, whether that be denial or obsessive or hysterical behavior. Common responses in addition to the above include disbelief, numbness, anger, chaos, and anxiety and fear.

Several studies (Cross, 1985; Temoshok, Mandel, Moulton, Solomon, & Zich, 1986) have reported that asymptomatic HIV-positive individuals are the most highly stressed group of people along the AIDS spectrum. This seems to be a result of feeling like one may be a walking time bomb—knowing one is not completely healthy and yet not having any serious signs of illness. People who are HIV-positive carry similar stressors to people with AIDS, yet they must also live with the uncertainty of it—when and how their infection will progress. There may exist a sense of little control over their eventual health course, and this can lead to a preoccupation with illness. Every cough, rash, or minor pain may trigger a panic reaction and fear that the infection is worsening. Other clients are relieved when, during allergy season, they develop runny noses and itchy eyes—a sign that their immune system is functioning at a healthy level. The HIV-infected individual who is on antiviral medication, such as AZT, will be reminded of this status each moment the timer goes off as a reminder to take the medication. Sleep cycles and daily patterns are interrupted at regular intervals several times a day. The often severe side effects of AZT, such as anemia, may also have a detrimental impact on psychological well-being. Those clients who receive regular T-cell counts as part of their medical regimen may struggle with anticipatory fear preceding the cell count, wondering if the number of T-cells in the system will be lower than in the previous measure. A lowered reading may cause depression as the client struggles with the fear that the immune system is weakening. The client may wonder if any life-style behaviors, nutrition

patterns, or negative beliefs may have contributed to the deteriorating count. If the count has increased, there is often an overwhelming sense of relief, occasionally accompanied by a feeling that the virus is no longer in the system. This struggle points out one of the most formidable tasks with which the HIV-positive individual has to cope— how to balance a feeling of hope and positive outlook with the realistic scientific and medical facts of the infection.

Jacobson, Perry, Scavusso, and Roberts (1987) reported that asymptomatic HIV-positive individuals score two to three standard deviations above the mean on measures of psychological distress. An important function of counseling for these individuals is learning stress reduction techniques (deep muscle relaxation, autohypnosis, meditation, yoga, exercise, etc.) that can be employed on a daily basis. Coates and McKusick (1987) found that the integration of stress management techniques has led to decreased anxiety and depression, lessened high-risk sexual behavior, and increased functioning of the immune system. In addition, it is common for individuals facing a serious illness to utilize denial in coping with the fear of losing physical health. Allowing the use of denial is essential when it enables the individual to "forget" that he or she is infected with HIV, and return to a normal day-to-day routine. As such, denial should be challenged only when its use compromises good medical advice. More often than not, clients (and counselors) need to be given permission to use a little denial now and then in an effort to decrease obsessing about the virus.

Another effective component of counseling is the process of expressing emotions, also termed abreaction. Affective expression has been found effective not only in combating isolation and depression, but it may actually have an immune enhancing effect. Certainly clients who are HIV-positive can be encouraged and supported in the expression of anger and rage, both at the virus itself, as well as at social discrimination. In addition, visualization can be a supplement to treatment in much the same manner as in cancer patients (Simonton, Matthews-Simonton, & Creighton, 1980). Visualization allows the client to individualize his or her response to the virus. Some clients prefer to imagine scenes of attacking and expelling the virus. Yet other clients seem more comfortable visualizing the body accepting and pacifying the virus, as if they are turning it off. Cognitive behavioral techniques, such a thought-stopping, self-talk, and reattributions can benefit the seropositive individual

by interrupting obsessive thoughts and ruminations. Other psychosocial factors, such as separation and divorce, bereavement, and relationship problems, have also been indicated as possibly affecting the functioning of the immune system (Kiecolt-Glaser & Glaser, 1988). Empowering clients by increasing the quality of their emotional and inner life can only enhance their lives and their relationships. Finally, researchers have reported on the benefits of antidepressant medication for those individuals who are immobilized by their depression (Fernandez, Levy, & Gallizzi, 1988) and on the use of benzodizepine to alleviate anxiety and panic attacks (Perry & Markowitz, 1986).

Sexuality

Other challenging issues may also be brought to the therapist. A concern such as how to incorporate sexuality into one's life may actually have complex overtones involving guilt and a negative self-image. Gay men, in particular, are susceptible to experiencing feelings of self-hatred that arise out of internalized homophobia. This form of self-denigration can often go as far as believing that one has brought this infection upon oneself because of being gay. It is imperative that counselors counter these feelings by exploring what role self-hate has played in the client's upbringing and inform the client that viruses do not discriminate but attack people from all walks of life. The homophobic reaction is most often noticed as a part of the bargaining state (Kübler-Ross, 1969) where the individual agrees never to practice homosexual behaviors again if God will cure him of the virus. In this context, the goal of therapy may be to acknowledge the feelings and help the client move through this stage of grief.

Eliminating sex from one's life is another drastic method of coping with being HIV-positive. Abstinence may be a valued choice for some people, but this decision should be reached only after careful exploration of underlying motivations. Safer sexual practices can allow an individual to maintain both erotic satisfaction and sexual intimacy. Many community AIDS resource centers are now sponsoring workshops that focus on eroticizing safer sexual practices. Individuals who become infected through sexual behavior—or who have infected others—may have a lot of working through to do before they can feel good about themselves as sexual beings. This includes expressing and dealing with guilt and shame, internalized erotophobia

(harboring negative feelings about sex), anger, and self-isolation from physical contact with others.

For gay men, even the adoption of safer sexual practices can be a tremendous loss to a self-image that was previously highly sexualized. Most gay men have had to strive to overcome indoctrination early in life that homosexuality is an abnormal perversion. One important means of countering these negative messages has been the open and free expression and exploration of sexuality, often in the form of multiple partners and various sexual acts that unfortunately can pass the virus from one person to another. The loss of this important source of self-affirmation and countering homophobic messages means that gay men have to rely more on other methods of boosting self-esteem (work, school, peers, spirituality). The giving up of past sexual behaviors results in a void that has to be filled in alternative ways by other facets of daily life. In addition, the gay man who has not yet developed a positive self-identity may experience difficulty proceeding with the coming-out process and forming an integrated view of himself. Again, the counselor can challenge this retardation as a sign of internalized homophobia. Heterosexual HIV-infected individuals will also struggle with how to maintain a healthy, rewarding, and safe sexual relationship with their partners. The counselor should actively inquire as to how the client's sexual behaviors are affected by the knowledge of HIV infection, because feelings of anger, shame, and fear may initially surface in the ways the client changes his or her sexual activity. These changes may take place on a broad spectrum, ranging from unnecessary withdrawal and isolation to uncontrollable and unsafe sexual acting-out. The counselor should avoid moralizing or scolding a client for engaging in unsafe behavior and should work to help the client deal with his or her sexuality as an inherently positive component of life. Instructing clients on safer sex and encouraging integration of these practices into relationships can provide clients with an element of control in their life, giving them behavioral choices they can practice and master, while enabling them responsibly to stop the spread of the virus and continue their personal growth.

Confidentiality and Legal Concerns

Another difficult issue in counseling and psychotherapy involves how to inform others and who should be informed of

the client's antibody status. Although it is preferable that the individual not be alone in his or her efforts to adapt to living with the virus, it is also imperative to be cautious about who is told given society's tendency to react negatively to AIDS-related issues. Telling too many people can result in problems such as loss of job and income, home, and friends. Therefore, landlords, employers, co-workers, everyday acquaintances, and young children probably should not be informed. Health care workers involved in treating the client such as physicians, nurses, dentists, and paramedics will need to be told in order to ensure effective medical treatment. The client may also want to discuss with his or her health care workers how this information will be recorded in medical or psychological records and when this information might be released to other agencies such as insurance companies or the military. The medical and mental health records will need to reflect an accurate course of treatment while counselors and health care workers remain sensitive to a client's need for protection.

Each individual will need to make responsible and careful decisions about how to inform significant others, partners and spouses, close friends, and family members. The chances of a particular person providing support or rejecting the client need to be carefully weighed. Role-playing difficult disclosure situations can help the client make decisions about the best way to inform those necessary to tell and decide whom not to tell. Although it seems responsible for the client to inform lovers, a spouse or partner, some will choose not to do so. This places the counselor in a difficult situation if the couple is not practicing safer sex. This disregard for spreading the virus may be a sign of other serious problems in the relationship between the HIV-positive individual and his or her partner, and the counselors should explore how anger is expressed in the relationship and what sources of dissatisfaction exist. The issue of confidentiality is also pertinent at this point. Counselors must struggle with their own discomfort and anger at the client who knowingly continues to engage in behavior that will possibly spread the virus. It is important that the counselor address this issue in a direct yet empathetic and nonpunitive manner that encourages the client to resolve his or her rage in a more responsible way. Several authors (Girard, Keese, Traver, & Cooksey, 1988; Kain, 1988) have noted that under these circumstances the counselor does not seem to have a duty to warn other parties. Melton (1988) pointed out that no legal or judicial cases

have provided guidance on how therapists should respond to this situation. It is possible that breaking confidentiality to warn others may result in more harm than good by damaging the therapeutic relationship. If an HIV-positive client continues to engage in unsafe sexual practices, the counselor may first want to consult with the ethics committee of his or her professional organization before breaking confidentiality. Local laws may provide public health officials with the power to act to prevent an individual from spreading HIV infection, so that if the counselor feels he or she needs to act to halt the client's behavior, reporting to these authorities may be the best recourse. In addition, if custody or visitation privileges are involved, the client would probably benefit from legal consultation before informing former partners of the HIV status.

Other legal issues that the counselor may want to address with his or her client include discussing the need for the client to have a will and authorizing a designated individual to have power of attorney. The latter procedure is particularly important for gay men or unmarried couples. This can provide some peace of mind and protect the client should his or her medical state worsen. Many gay couples without such protection have experienced family members taking over all rights to making medical decisions. In many cases, the wishes of the ill individual and the gay partner have been rejected by homophobic family members. The power of attorney can legally invest a partner of a trusted friend with the authority to make certain medical and legal decisions, such as which medical interventions can be used and what rights of visitation apply, so that the patient's wishes are preserved. Although taking such legal steps is in the best interest of the client, the counselor needs to take cues from the client about when he or she is ready to make such decisions. In addition, these measures should be approached in a proactive, affirming manner designed to provide clients with more control over their lives, and not as a step toward preparing for immediate death. These are actions that would benefit all people (not only the HIV-infected) in preparing for eventual death.

Countertransference

The counselor's own attitude and feelings toward HIV-positive clients will be of primary importance in allowing the establishment of a safe, a trusting therapeutic relationship.

Counselors need to be aware that little is known about the course of AIDS, and that a large percentage of antibody-positive individuals have lived many years with no symptomatology. In addition, others have developed mild symptoms only to see them disappear with medical treatment.

This points to the importance of instilling in the client a positive, life-enhancing outlook. In fact, Faltz and Madover (1987) suggested that many individuals who previously had led lives encumbered by severe drug and alcohol use and shallow relationships have greatly enhanced the quality of their day-to-day endeavors since learning they were HIV-positive. Although AIDS can be devastating, we do not know it to be a sure death sentence. The importance of positive thinking and an affirmative life style have been shown to be effective adjuncts in treating life-threatening chronic illnesses (Seigal, 1986). Therefore, it is important for the counselor to pay attention to his or her own feelings regarding countertransference, which may be more subtle and hidden when working with an asymptomatic individual as compared to someone with full-blown AIDS. The counselor will probably have to deal with his or her own concerns about fear, uncertainty, anxiety, anger, homosexuality, drugs, and death. Rosse (1985) found that 73% of inpatient psychiatric staff harbored fears of contagion through casual contact even thought medical science has consistently shown that transmission of the virus is limited to blood-to-blood or semen-to-blood contact.

Faltz and Madover (1987) discussed two other powerful countertransference issues: the need for professional omnipotence and overidentification with the client. The former concern has to do with the therapist's own helplessness to sometimes effectively enable people to change behaviors or to ultimately alter the course of the HIV infection. For unknown reasons, some individuals who seem to have adopted healthy behaviors and attitudes still advance to a more serious level of the infection. It can be extremely difficult for both the client and the caring counselor to accept a transition from being HIV-positive to being diagnosed with AIDS. The resultant crisis will demand an immediate response to cope with the advance of the infection to this level. The transition from HIV-positive status to AIDS can be a frustrating and drawn-out expensive experience that involves numerous tests, procedures, and doctors. Haney (1988) noted that after going through such an ordeal, most clients expect to be prepared for the AIDS diagnosis. What often oc-

curs, however, is another severe crisis during which psychological support is crucially needed to prevent fear and anger from turning into self-destructive behavior. Overidentification with the client can occur particularly when the counselor shares common concerns in his or her own life, such as "Am I infected with the virus?" Problems for counselors in this situation include pushing the client toward changes too fast or letting their own values dominate clinical decisions. Counselors who are at risk for HIV infections need to take care of their own concerns, independently of their relationships with their clients.

Another difficult situation for the counselor involves having to confront an "ill" individual when the individual is engaging in behaviors that are not therapeutic. Some counselors may be reluctant to bring up difficult issues when working with a client who is already coping with multiple stressors. However, the counselor's position with the client may be vital in that he or she may be the only person in the client's life willing to bring up unpleasant topics such as drug and alcohol use and unsafe sexual behavior. Discussing these behaviors provides an opportunity to deepen the therapeutic relationship and enables the client to learn more about his or her manner of relating to others. In addition, counselors need to remain cognizant of their dual responsibility to the client and to society at large. Bohm (1987) pointed out that educated HIV-positive individuals who continue unsafe sexual behavior are engaging in denial and expressing their anger. Therapy in this case should not avoid the issues but focus on the underlying motivations behind unsafe activities. This includes exploring why such clients have chosen to expose themselves and others to the virus, and what is occurring in their life that is causing them to engage in repeated attempts to risk their own or others' lives. The counselor should ask the clients about sexual or drug-related behavior, even if the clients do not volunteer this information. This reinforces that the counselor places a high priority on stopping the spread of the virus.

Every individual has his or her own characteristic manner of reponding to stress. Some will cope with pain and stress through increased risky behaviors, such as compulsive sexual activity or abusing drugs and alcohol. Others may withdraw and isolate themselves or engage in increased hypochondriacal complaints. The counselor will need to assess the client's ability to cope with stress by evaluating past relationships, education and career achievements, level of self-esteem and identity for-

mation, previous coping skills, and the degree of support from caring others. The degree of development of the client's own psychological characteristics will play a major role in determining how the individual tolerates the uncertainty of being HIV-positive. Faltz and Madover (1987) emphasized that the crisis brought on by learning one is HIV-positive may prove to be the opportunity to enhance one's life tremendously. The counselor, while adopting an optimistic outlook, should avoid minimizing or denying the real fears and anxieties of the seropositive individual.

Special Considerations

Other concerns will often need to be addressed in counseling to fully provide a broad-spectrum intervention for the client. These issues include: the needs of significant others, specific concerns for women, suicide, central nervous system (CNS) impairment, and group therapy. The counselor may often be involved not only with working with the antibody client, but also his or her spouse or partner and family members. The client's significant others, who are most often the primary caregivers, will also experience grief and an adaptation period (Fuller, Geis, & Rush, 1988; Greif & Porembski, 1988). Many communities also offer support groups for the loved ones of those infected by the virus. These groups serve not only to counter isolation but also to dispel blame and guilt and provide information. In addition, some groups have formed for those who are survivors of losing a loved one to AIDS. Many HIV-positive clients indeed already have lost their partner or numerous friends. Grieving is a natural healing process and as such, can be fostered in the therapeutic alliance with a trusted counselor.

Women who test positive for the AIDS antibody should be counseled about the chronicity of the infection and the chances of passing the virus on to offspring during pregnancy or at the time of delivery. Kapila and Kloser (1988) cited a 50% chance that the infant of an HIV-positive woman would also harbor the virus. Additionally, women who are considering artificial insemination by a donor should take precautions to screen donors for HIV.

The HIV-positive individual faces many difficult and seemingly insurmountable problems. People with this infection are

among the highest at risk to attempt taking their own lives, and each counselor should be proactive in assessing the possibility of such action by the client (Flavin & Francis, 1987). Suicidal ideation is likely to occur both at the moment of diagnosis, when the crisis seems overwhelming to the client, as well as at any time following the news of seroconversion. Repeated rejection by friends and loved ones, death of loved ones, societal oppression, discrimination, and a worsening physical state can all trigger feelings of hopelessness and a desire to have some control over how one dies. In addition, some individuals contemplate suicide because of the shame they feel about developing AIDS and being exposed as either IV drug users or gay. Suicidal tendencies may also surface in less obvious, yet seriously self-destructive behaviors such as drug and alcohol abuse, continued exposure to repeated infection by the virus, or other forms of life-risking behaviors as a means of coping with stress.

It has been well established that the AIDS virus crosses the blood-brain barrier and enters the central nervous system. Many HIV-infected individuals may begin to show early signs of CNS involvement, including mild cognitive impairment, forgetfulness, decreased concentration, and short-term memory loss. The counselor may have difficulty discerning if these symptoms are caused by anxiety and depression or by advancing illness. It is important to note that in some individuals, cognitive impairment and AIDS dementia are the first indications of deterioration (Wolcott, 1986; Christopher, 1988). If the symptoms persist and seem nonremedial to counseling, then a neurological referral is appropriate to determine the severity and course of the cognitive impairment.

Lastly, an important component of treating the HIV-infected individual involves referring the client to a supportive group experience. A variety of group formats have been used and shown effective in countering isolation, providing education, and decreasing risky behavior. If possible, it is more effective to offer separate groups for individuals who are affected differently by the virus. Spector and Conklin (1987) advised that asymptomatic HIV-positive people not be mixed with people with AIDS because the presence of individuals with an advanced illness often intensifies the fears of others, motivating them to drop out of the group early. Because significant others have their own special concerns, often groups are organized just for their needs (Klem & Fletcher, 1987). In addition, gay men, women, and IV drug users typically have different life styles

and issues to resolve, and it is common to offer separate group experiences for each. Galea, Lewis, and Baker (1988) reported that a discussion group format proved helpful in treating long-term substance abusers. They found that the group showed increased health concerns in a population where health is usually not considered important. Those who remained in the group also had a greater rate of staying in treatment, because dropping out of the group could mean a return to behavior that might lead to infection. Other authors (Lauers-Listhaus & Watterson, 1988; Posey, 1988) also reported that the psychoeducational group experience is effective in dealing with reducing behavior that may pass the virus on to others as well as providing a powerful format for confronting other forms of self-destructive behavior (Price, Omizo, & Hammett, 1986). The group experience may be the only haven a client or significant other has that provides acceptance, safety, and reassurance while dispelling the blame and guilt often associated with AIDS.

Conclusion

The effort to provide counseling and psychotherapy to the HIV-positive client calls upon our most human traits and can challenge our own feelings about our sexuality and mortality. The counselor must convey a hopeful, positive, and caring attitude that in itself can be healing without minimizing the real and painful struggles the client has to endure. Life is a fragile existence that can be lost at any moment. For the HIV-positive client, the struggle centers around how to live life deeply and with meaning in the here-and-now while preparing for an uncertain future. As therapists, it is our responsibility to prevent this virus from destroying self-respect.

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Chapter 4

THE FORGOTTEN SEVEN PERCENT: WOMEN AND AIDS

Margaret Nichols

Introduction: Five Case Vignettes

Sylvia, a Black woman, divorced her first husband, a drug addict, 6 years ago and remarried a non-drug using man shortly thereafter. Two years ago she began to exhibit vague symptoms that were incorrectly diagnosed as psychosomatic. It did not occur to either her or her physician that she might be HIV-infected, so she was psychiatrically hospitalized with a diagnosis of bulimia, due to her frequent vomiting. Last spring Sylvia's ex-husband called her to inform her of his HIV seropositive status. She died within a month of learning that her symptoms were HIV-related, rather than psychiatric. Her grief-stricken second husband, himself now seropositive, apparently infected by Sylvia, now cares for his two children from a previous marriage as well as two children from Sylvia's first marriage.

Susan, a 29-year-old White working class woman, also suffered symptoms that were misdiagnosed for a year. In her third month of pregnancy, Susan mentioned to her doctor that she had had several different sexual partners since adolescence. On the basis of this clue, her doctor finally referred her for HIV antibody testing, and Susan received an ARC diagnosis when her test results were positive. Only at this point did her steady male sexual partner of 4 years, the father of her child, admit his past homosexual behavior. He told Susan that he had been afraid to tell her because he was afraid she would leave him.

He also said that he never considered himself to be at risk for AIDS because "AIDS happens to homosexuals, not bisexuals." Bobby, Susan's boyfriend, subsequently was diagnosed with ARC himself. Susan was told, in her fourth month of pregnancy, that if she carried her baby to term, both she and the baby would probably die. Frantic, she left on her own to seek an abortion, but was unable to find a clinic that would agree to perform the more complicated second trimester procedure on an HIV-infected woman. In her fifth month, on the same day she finally found a clinic that would perform the abortion, Susan's baby moved inside her for the first time and she was unable to go through with the abortion. Susan's daughter was born in August and was healthy when Susan was first interviewed by a counselor. Susan, however, had contracted toxoplasmosis in September. When Susan recovered from this opportunistic infection, she said that, on her good days, she thought about having a second baby. She believed, incorrectly, that if her daughter remained healthy, a second child would also be healthy. On the other hand, Susan also sensed subconsciously that if her baby became ill, she would feel a desperate need to try to replace her sick baby with a healthy one. For Susan, being a mother was life-affirming and helped her maintain a hopeful attitude toward her own illness, an attitude that ironically was psychologically adaptive in many ways though it might have led to another dangerous pregnancy. Eventually, all three—Susan, Bobby, and the baby—developed full-blown AIDS.

Clarissa is 23, a Puerto Rican woman who lived in Jersey City, New Jersey, one of the top 10 cities in terms of the number of AIDS cases. Like Sylvia, her first husband was an addict. Clarissa learned she was seropositive when she was routinely tested during pregnancy. Her deep religiosity, among other things, prevented her from aborting this pregnancy, and her first child was born with AIDS. Soon after this birth, her first husband died of AIDS. When Clarissa's little boy was a year old, she met another man who, from Clarissa's point of view, fell in love with her and moved in to live with her and support her despite her seropositive status. Clarissa's new partner asked to have a second child—he wanted her to have his baby—and Clarissa complied. She never considered not complying, in fact, and left her fate, in her view, in the hands of God. When Clarissa was 7 months pregnant, her little boy died.

Nancy, a 28-year-old White nurse practitioner, came from an upper-middle class professional background. One day all

the nurses who worked in her office, concerned about past needle-sticks, decided to go as a group to take the HIV antibody test. Two weeks later Nancy was dumbstruck to learn that she tested positive. For a long time she racked her brain to try to imagine how she had been exposed to HIV. She began to call all her past boyfriends and, finally, when she contacted a man she had been involved with 7 years earlier, she learned that, unbeknownst to her, he had been an IV drug user and that he too was antibody positive. Soon after, Nancy began to develop the symptoms of ARC. She first reacted by withdrawing and isolating herself, feeling alienated from her peers who, in fact, did not know how to handle this situation. Nancy then joined a peer support group for people with AIDS and ARC. She was the only woman in the group—the rest were gay men or male IV drug users—but Nancy didn't care. These men became her new peer support group, and eventually Nancy turned her depression and isolation into action: she did AIDS volunteer work and participated in AIDS-related political activities.

Cindy, 20, grew up in a poor White family where she was physically and sexually abused. By the age of 12 she was a runaway, sleeping in abandoned cars. Her husband is an addict who was diagnosed with AIDS when their baby was 5 months old. Cindy, Richard, and the baby have an income of $136 per month from local welfare because Richard's Social Security disability benefit was denied when his clinic doctor filled out the paperwork incorrectly. Cindy and the baby are healthy, but Cindy didn't want Richard to use condoms in their sexual relationship even after his diagnosis. During group counseling, Cindy verbalized her fantasy that, if she contracted AIDS, her abusive and neglectful family might "come around" and care for her in a way they had never loved her as a child. The group persuaded her to give up this fantasy and she began to have safer sex with Richard.

Epidemiology of AIDS in Women

Although women compose only 7% of all reported AIDS patients in the United States, they are an important potential source for heterosexual HIV transmission as well as the source of transmission to infants. In New York City in late 1987, for example, one in 61 infants was born with the antibodies to the AIDS virus (Brooks-Gunn, Boyer, & Hein, 1988). Moreover,

recent trends indicate increases in sexually transmitted cases in U.S.-born women, suggesting an increase in the heterosexual transmission of the AIDS virus to women (Hardy & Gunnan, 1987).

To some extent, the relatively low overall percentage of female AIDS cases in the United States (compared to, for example, the 50% rate in parts of Africa) is misleading because it reflects primarily the fact that AIDS in this country was first diagnosed among gay men. Here, areas in which AIDS is found among intravenous drug users tend to have a higher percentage of women, reflecting not only the incidence of AIDS among female drug users but also heterosexual transmission from male addicts to their partners. New Jersey, where 17% of AIDS cases are women, has the highest percentage of female AIDS cases. New York, another state with many intravenous drug user cases (IVDUs) has 11% female AIDS patients.

The 7% overall figure for women has remained stable since 1982. If one analyzes risk factors for heterosexual men and women, (see Table 1), it is clear that intravenous drug use is the primary transmission mode (52%) for women, just as it is for men (68%). The most noteworthy differences in risk factors between men and women are that a higher percentage of women contracted AIDS through heterosexual sexual contact than did men (21% versus 1%). In absolute numbers, female sexual transmission cases outnumber male cases by a ratio of five to one.

TABLE 1

Heterosexual Men and Women With AIDS by Sex and Transmission Category 1981–1986

Risk Group	*Men*	*Women*	*M:F Ratio*
IVDU	68%	52%	1:1
Heterosexual contact	1%	21%	0.2:1
Endemic area	8%	6%	1:1
Hemophiliac	1%	1%	33:1
Transfusions	6%	10%	2:1
Undetermined	12%	11%	3:1
Total Cases	5,358	729	3:1

Note. From "Epidemiology of AIDS in Women in the United States: 1981 through 1986" by M.F. Gunnan and A.M. Hardy, 1987, *Journal of the American Medical Association, 257*, p. 2040. Copyright 1987 by the AMA. Adapted by permission.

It is difficult to interpret these data accurately, and indeed their interpretation remains one of the unanswered questions about AIDS transmission in this country. One theory that has been advanced to explain the disparate rates of U.S. female versus male heterosexual sexual transmission holds that it is merely an artifact of the stage of the epidemic we happen to be in at this time. That is, we know that AIDS first appeared in this country in mass numbers among gay men—who primarily transmit to other men—and via shared needles among intravenous drug users, 75% to 80% of whom are men. Thus it is logical that the first AIDS victims would overwhelmingly be men, but it does not mean that at some later stage in the epidemic male to female ratios could not be equal. Another theory holds that female-to-male vaginal intercourse may be a much less efficient mode of transmission than is male-to-female transmission. If this is true, there may never be as many female AIDS cases as there are male, but there will always be more women who acquire AIDS through sexual transmission than heterosexual men.

Table 2 shows risk factors of the male partners who presumably infected women who contracted AIDS through heterosexual activity. As one would expect, the majority of these male partners were intravenous drug users. A much smaller percentage were bisexual men. A comparatively large percentage—16%—reported basically unknown risks, and this is significant because, as will be discussed a bit later, women often tend not to know how they have been infected.

If one analyzes the epidemiological data on women with AIDS in order to predict future trends, one sees that, over time, higher percentages of women have become infected with AIDS via a sexual route versus other risk factors, with no correspond-

TABLE 2

AIDS in Women: Heterosexual Transmission
C.D.C. Statistics
Risk Factors for Heterosexual Contacts

Intravenous drug user	67%
Bisexual men	16%
Hemophiliac men	1%
Other unreported risks	16%

Note: From "Epidemiology of AIDS in Women in the United States, 1981 through 1986," by M.E. Guinan and A.M. Hardy, 1987, *Journal of the American Medical Association, 257*, p. 2041. Copyright 1987 by the AMA. Adapted by permission.

ing increase in heterosexual transmission in men (see Table 3). Moreover, there is a 10-month doubling time for the mostly female heterosexual transmitted cases as opposed to a 14-month doubling time for gay male and intravenous drug user cases (Hardy & Guinan, 1987). In other words, in the future, heterosexual women who contract AIDS sexually will be a rapidly multiplying risk group that could theoretically grow to compose as many AIDS cases as are now seen among gay men and drug users. Of course, if this happens, there will be a correspondingly rapid rise in the number of infants born infected—a phenomenon already occurring in New York City.

When one looks at other characteristics of women with AIDS, one sees that AIDS is not spread evenly among racial or social classes, as it is more or less among gay men. Overall, both male and female heterosexuals with AIDS in the United States tend to be people of color—half Black and about one quarter Hispanic. As one would expect, children with AIDS are young. AIDS affects women in their childbearing years, with one third of women with AIDS being 29 years old or younger and another 45% between the ages of 30 and 39 (Guinan & Hardy, 1987).

These data reflect the fact that there are currently in the United States two major, and only somewhat overlapping, AIDS epidemics. One is among homosexually active men who are infecting mostly each other (although not exclusively) and whose behavior has changed so drastically that the rate of newly infected people in this group is probably very small. The second epidemic is among poor, minority people in urban centers where intravenous drug use and shared needle use is common. This

TABLE 3

Significant Trends in AIDS in Women
1982–1987
($p < 0.05$)

	1982	*1986*
Increase in U.S.-born heterosexual contacts	11.0%	26.0%
Increase in mean age	30 yrs.	35.6 yrs.
Decrease in female IVDUs	59.0%	48.0%
Decrease in foreign-born heterosexual women	18.0%	5.0%

Note: From "Epidemiology of AIDS in Women in the United States, 1981 through 1986," by M.E. Guinan and A.M. Hardy, 1987, *Journal of the American Medical Association, 257*, p. 2040. Copyright 1987 by the AMA. Adapted by permission.

epidemic started with mostly male and some female drug users, and the female drug users' children, but is spreading to include women who are not drug users but who have been the sexual partners of drug users, and their children. Depending upon factors such as the case of female-to-male transmission and rates of female partner change, this "second epidemic" could eventually outstrip and dwarf the first. If unchecked it could become a disease of poor minority heterosexuals and their children who live in urban centers. This is the most likely spread to the so-called "general population." Whether this epidemiological spread will continue into the White heterosexual middle class will depend upon factors such as rates of intravenous drug use among the middle class, and rates of sexual contacts across racial barriers and across social classes.

Another source of spread to White middle-class women is through the activity of functionally bisexual men, both men who label themselves bisexual (a very small percentage of all men), men who identify as heterosexuals but who have clandestine homosexual activity, and men who identify themselves as gay but have some continuing heterosexual activity. The approximately 3% of women with AIDS who contracted AIDS through bisexual men are a harbinger of this trend, which, through tertiary female-to-male sexual spread, could introduce a new type of risk group: White middle-class heterosexuals whose only source of infection is sexual contact with other White non-drug using heterosexuals. It is impossible to predict the rate or likelihood of substantial spread in this way presently because there are too many unknown, unmeasured variables that could affect this transmission, including the true rate of bisexual activity in the United States. Part of the difficulty in describing or predicting the course of the AIDS epidemic among women (and thus among children and non-intravenous drug using heterosexuals) lies in the fact that there are so few cohort studies of women such as the ones in progress studying AIDS among gay men. In the absence of such studies, counselors must piece together a picture of women and AIDS from bits of data gathered in high incidence areas. Among the most relevant statistics are the following:

- In New York City AIDS is the leading cause of death for all women between 25–34 years of age (Krstal, 1986).
- A sample of women with AIDS at Montefiore Hospital in New York showed that 35 women had a total of 52

dependent children. This underscores the fact that women with AIDS don't simply bear infected children, but they also already have other children. In fact, the problem of "AIDS orphans" is a much bigger problem in numbers than that of pediatric AIDS (Friedland, 1985).

- Women who are HIV-infected stand a 35% to 50% chance of bearing an infected infant (Peckham, Sentuvia, & Ades, 1987). Moreover, most pregnant seropositive women choose not to terminate their pregnancies, even when informed of the risk. A study in New York reported that of 80 pregnant seropositive women only one chose to abort. These figures reflect the tremendous role that motherhood plays in the lives of women who do not have access to other social roles or to other sources of self-esteem, pleasure, and life gratification. Moreover, to many poor women whose lives are already full of risk, even the 50–50 odds of having a healthy baby represent a comparatively acceptable risk. Coupled with these factors are variables such as religious beliefs about abortion and mistrust of doctors and health authorities who convey risk information.
- A study done at Downstate Medical Center in New York (Landesman, Minkoff, Holman, McCabe, & Sijm, 1987) that matched both subjects' and interviewers' judgments about a woman's serostatus with actual serostatus as determined by blood samples showed that the interviewers were not able to classify 42% of the at-risk women properly and that two thirds of the women themselves were unaware of a positive antibody status. Only intravenous drug-using women were both aware of their own risk and seemed obviously at risk to the trained interviewers. In other words, women who became HIV-infected through sexual transmission were usually unaware that they were at risk. This is probably because, in general, the pattern of sexual transmission to women is different from that to gay men. Both Padian et al. (1987) and Cohen, Hauer, Poole, and Wotsy (1987) found that, unlike among gay men, having multiple sexual partners is not the highest risk factor for women. Most women who have contracted AIDS sexually and who have not had multiple partners have become infected by multiple exposures over time to a new infected man who was either unaware himself of his risk status or was deceiving his female partner.

Thus, for women, so-called "promiscuity" does not at this time seem to be related to infection. Unfortunately, this is not widely known, and women who are in what they consider to be monogamous, stable relationships are probably lulled into a false sense of security by the media emphasis upon multiple partners as a risk factor for AIDS.

- Although anal sex is probably a more efficient route of transmission than vaginal sex (Padian et al., 1987), it is clear that vaginal sex is sufficient. It also seems, from the few data collected, that it takes, on the average, a rather large number of exposures for women to become infected through vaginal intercourse. Moreover, it seems clear that condom use does provide protection (Fischl, Dickinson, Scott, Klimas, Fletcher, & Parks, 1987). However, because the precise route of transmission to women is unknown—particularly whether transmission takes place through the vagina, cervix, or uterine lining—other mechanisms of prevention for women cannot be confidently recommended. This presents great difficulties to women because they must persuade their male partners to use condoms instead of having a method (e.g., diaphragm with spermicidal jelly, cervical sponge) that they can use themselves.

Counseling Women About AIDS: Prevention

In the absence of comprehensive data, counselors must nevertheless increase and improve prevention efforts aimed toward women. There is no ongoing research on the efficacy of prevention strategies for women, but some survey reports, such as that done by Joyce Jackson in New Jersey, suggest that women in the minority urban populations who are at risk have a good deal of knowledge about how AIDS is spread but are nevertheless not practicing safer sex techniques—not insisting that their male partners use condoms. Interestingly, the only women showing significant behavior change are prostitutes: the Centers for Disease Control Multi-Center Prostitute Study (Centers for Disease Control, 1987) shows that 78% of prostitutes now insist that their male customers use condoms. However, even the prostitutes who make customers use condoms don't ask their boyfriends or spouses to use condoms.

Any prevention efforts targeted toward women must address the issue of why even those women knowledgeable about

AIDS don't insist upon condom use for sex. The reasons are complex, are not entirely clear, and probably are bound up in sex-role socialization and social class issues. To begin with, women in this culture are socialized to defer to men in the setting of limits for sex: Men usually determine how, when, and how often sex will occur. For a woman to suggest condom use, she must first overcome her internal barrier to setting any sexual limits. Moreover, for women sex is less likely to fulfill a pleasure function than it is to fulfill more pragmatic functions. Among these is the role of sex as a barter exchange for the financial support of a male partner. A poor woman, in particular, often cannot afford to alienate the man who supports her and her children. Many urban poor minority women at risk report fears of abandonment or even physical assault if they suggest condom use, and these women cannot simply replace a recalcitrant partner with a more compliant one that easily. Related to this is the notion of relative risk and temporally close versus temporally distant risk: If a woman balances the risk of AIDS in the future against the immediate loss of food and shelter for her and her children, safer sex loses.

A major obstacle to effective prevention for women is AIDS educators' failure to convince men of the necessity to use condoms. Safer sex messages have been in the gay male community for a number of reasons, but among these is the fact that these messages appeal more to the desire to protect oneself than the altruistic desire to protect others. That is, gay men are told to use condoms because they themselves risk AIDS from both insertive and receptive anal intercourse. Most heterosexual men have the (erroneous) impression that condoms are necessary only to protect their female partners, and thus educators are relying solely upon an altruistic motive rather than addressing the motive of self-interest. This is doubly difficult because condom use interferes with a rather rigid sexual repertoire among heterosexuals, compared with the repertoire for gay men. That is, gay men have never been as focused upon anal intercourse as a sexual mode as heterosexuals are focused upon vaginal intercourse.

Among drug users the real significance of sexual transmission has been obscured by grouping those with multiple risk factors as "IVDU" cases. In other words, a drug abusing woman who contracts AIDS is presumed to have been infected through needle use, although she may indeed have been infected through sex. Because counselors and educators tend to view all cases of

AIDS among drug users as needle-related, they underemphasize the role of sexual transmission to the very population in which they would like to change sexual habits.

It has been particularly difficult for (mostly) White professionals in the health care field to reach minority populations in an effective way. These groups often have grave mistrust of a White bureaucracy, often based upon many years of negative experiences with hospitals, social service agencies, and so forth. For example, counselors at New Jersey's AIDS service organization, the Hyacinth Foundation, are frequently asked to respond to questions from Black audiences about whether AIDS itself is a plot by the United States government to eradicate Blacks. Stories are common, both in New Jersey and New York, about health care workers being assaulted in minority communities while attempting to do prevention work handing out condoms.

As mentioned before, the impression that AIDS is associated with multiple sexual partners works against prevention efforts with women in two ways. First, it lulls some women into a false sense of security. Second, to most heterosexuals, male and female, "multiple sexual partners" translates into the pejorative term "promiscuity." This means that a woman who asks a man to use a condom is implying either that she has been promiscuous or that he has been. And finally, it is sometimes difficult for women to ask men to use condoms because women have been socialized to protect their male partners emotionally. For example, some women say they can't ask their partners to use condoms for fear of hurting their feelings; these women truly are prepared to die for love.

What, then, constitutes effective prevention strategies for women? First, on an organizational level, target prevention for the group that needs it most: inner city minority women of childbearing age. Prevention work will most effectively be done by people indigenous to the community and, for most women, by another woman. Race, class, language, and age must be considered in designing prevention strategies.

Second, construct interventions that realistically take into account the roles that sex plays in women's lives. The gay male community's emphasis upon "eroticizing safe sex," for example, is not particularly relevant to most women. What is more effective are, for example, techniques such as role-playing that help women learn how to broach the subject of condom use to their partner, or small, women-only group discussions during

which participants can share feelings, fears, and successful prevention methods.

Third, convey information relevant to women, not gay men. Women need to be told that AIDS is most frequently transmitted among heterosexuals in long-term partnerships, not through multiple partners. They should be told that becoming infected can frequently take years of multiple exposures, to combat the hopeless attitude that "If I'm going to get it from him, I've already gotten it, so why start safe sex now?" Emphasize the risk from vaginal and anal sex—it is questionable whether oral sex is a vector of transmission. One is more likely to effect behavior change if one asks for change in one or two behaviors, not a whole laundry list of "possible safe" or "probably safe" behaviors. Although it is most cautious to suggest using two barriers (e.g., condoms and foam, or condoms and a diaphragm), it is also important to be realistic. Counselors at the Hyacinth Foundation tell women that if they are completely unsuccessful at getting their partners to use condoms, that other barrier methods that contain the spermicidal agent nonoxynol-9 are probably better than nothing.

Finally, target heterosexual men, not women. Here, at least two methods are important, besides the altruistic appeal to men to protect the ones they love. First, it is important to convince heterosexual men that they, too, are at risk from vaginal intercourse without a condom; it is clear that, though female to male sexual transmission may be relatively rare, it does exist. Second, one must try to get heterosexual men to change the ingrained mind-set that sex that does not include penetration of and ejaculation into a vagina (or anus) is not "real" sex. This, of course, is difficult, to say the least.

Counseling HIV-Infected Women

One of the first things a counselor must remember in dealing with HIV-infected women is that few women suspect that they are antibody positive, or infected, and that few doctors detect HIV infection, unless the woman is an intravenous drug user or reports that she is the partner of someone in a risk group. As data show, many women do not know the risk status of the men with whom they are involved. In fact, a survey of heterosexual men and women in the "general population" indicated that most women rely on simply asking their male sexual

partners about risk status as their primary mode of AIDS prevention, and that approximately 50% of men said that they would lie about risk status or even antibody status in order to have sex with a woman. Thus counselors must play the unwelcome role of being the person to question risk for AIDS. Frequently the women most concerned about AIDS are the ones least likely to be at risk—middle-class women who are already somewhat phobic about sex—whereas those most at risk are also most likely to be in denial. Kathy, for example, was a middle-class woman who had a past history of intravenous drug use but who had been "clean" for 5 years. She and her husband—who knew of her past drug history—planned to have a child, and Kathy's denial regarding AIDS was so extreme that in all her medical visits to gynecologists and obstetricians she never mentioned her drug history and never asked to be tested. Finally, close to the end of her first trimester of pregnancy, her physician tested her for HIV antibodies as part of a battery of tests, and her test results were positive. Even then, the counseling she received all focused upon the odds of her baby being born infected. When she came to see a counselor, the counselor was the first person to tell her the unpleasant news that her odds of leaving her child an orphan were greater than her odds of bearing an infected baby. Despite learning of her antibody positive status, her denial was so great that it had simply not occurred to her that she might get sick and die. Thus often the most useful function a counselor can serve is to be informed about AIDS and break through clients' ignorance or denial, an ignorance or denial that health care providers may match or reinforce.

It is important for counselors to be aware that HIV-infected women are, of all persons with AIDS, perhaps the most isolated, least supported, and least cohesive group. For example, gay men who are HIV-infected have a tremendous community of support; even IVDU men who are HIV-infected have a shared bond, that of being drug users or former drug users. Because of the relatively small number of women with AIDS and because of the diversity of ways in which women can become infected with AIDS, women often find themselves most alone and feel most stigmatized. And indeed, they probably are. Partly because the level of infection is so high in the gay community, seropositive gay men can still find sexual or romantic partners. This is not true of infected women: A woman who finds herself with HIV is not likely to find another sexual or romantic partner

unless she already has one or is prepared to lie. So it is not surprising that women, even more than men, feel that their lives have ended once they are infected. Group support is important for all people with AIDS; it is even more important for women. But counselors may have a hard time finding support groups for women outside of large urban areas. In these situations, it is probably helpful for counselors to try to connect women with AIDS with each other even on a one-to-one basis.

Women with AIDS are also even more likely than many others to blame themselves and be consumed with guilt and self-hatred about their infection. The fact that AIDS is associated with sex and drugs makes self-blame likely for all HIV-infected people; for women, this self-blame becomes an overlay on the cultural messages they have already received about "good girl" versus "bad girl." The self-blame reaches an almost unbearable level when children are involved. HIV-infected women with healthy children feel guilt about leaving these children behind, and women who bear infected children feel responsibility for infecting their own babies. Often, counseling must focus almost exclusively on these issues of self-hatred and blame. One of the most useful things a counselor might do for a women with AIDS could be to help her forgive herself before she dies.

Counseling with women who are HIV-infected must be pragmatic as well. Women with AIDS are likely to be poor and to be minority group members. Especially if they have children, their social service needs are many and their resources few. Counselors must be prepared to be advocates for them and to help them obtain whatever governmental entitlements they can. Counselors working with HIV-infected women may find that simple needs for housing, food, and appropriate medical care are far more important than psychological issues. Some of the social service needs these women have will involve helping them prepare to leave their children behind and to find proper homes for them. Because good foster care or adoptive care is difficult to find for these children, counselors must also help an HIV-infected woman make use of extended family networks or other support systems within her community.

It can be particularly difficult for counselors to handle their countertransference feelings when dealing with HIV-infected women. For example, it is easy to pass judgment upon an infected woman who chooses to carry a pregnancy to term, making it particularly important for the counselor to examine his

or her own negative reaction to this. Speaking personally, as a woman who is a mother of a small child, it has been almost unbearably painful to work with HIV-infected women with children, especially when those children themselves are infected. Overidentification with the client is easy, and it is almost a requirement of this kind of counseling that the counselor be in therapy or a professional peer support group of some kind. As the death and dying counselor, Stephen Levine, said, this work requires nothing less than therapists or counselors being able to keep their heart open in hell.

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Chapter 5

SPECIAL NEEDS OF TODAY'S ADOLESCENTS

Barbara R. Slater

The current AIDS crisis affects all society, with particular meaning for youth. Counselors working with youth who are affected by AIDS need to look at the dual educative and therapeutic aspects in their ongoing work. Almost all children and adolescents attend school and, therefore, schools are drawn into the heart of the crisis as major vehicles for providing current, accurate information on HIV characteristics, transmission, and prevention. Counselors working with youth need to consider schools as a focus of educative programs, with strong liaisons to other organizations that have specialized AIDS-related services.

Because other chapters in this text and other experts in the field have written extensively about the history and current status of information about AIDS, this chapter will not attend to these issues but, rather, will address the specific needs of youth. According to October, 1988, data from the Centers for Disease Control (1988b), 75,768 persons have been documented as having AIDS. 1,202 of them are younger than 13 and 365 are between ages 13 and 20. The CDC anticipates as many as 3,000 diagnosed childhood AIDS cases (under age 13) in the United States by 1991 (CDC, 1988a) and others feel that this figure may reach 20,000 (Diamond & Cohen, 1987; Oleske, 1987). The number of adolescents with AIDS is comparatively small but it is doubling each year (Brooks-Gunn, Boyer, & Hein, 1988). Counselors will be working with these young persons as they progress through childhood and into adolescence, should they survive that long.

Minority youth are differentially affected by AIDS so that counselors will want to consider the specific needs of minority youth in their work. The CDC (1988b) reported that as of October 18, 1988, among those under age 20, White children and youth accounted for 28% (425) of the cases of AIDS, Black children and youth for 49% (735), Hispanic children and youth for 22% (330), and others for 1% (11). These figures clearly do not reflect overall population characteristics.

We have no estimate of how many other young persons there are who are HIV-infected (seropositive) but undetected, all of them carriers of the HIV. In addition to those children and youth who have AIDS, those who have AIDS-related complex (ARC) and demonstrate some AIDS-related symptoms and those who are HIV-positive but asymptomatic also must be considered. Although many lay persons lump these categories together, the needs of the affected persons are different. Still another category is the "worried well," youth who are not infected but who are extremely anxious because they engage in high-risk behaviors or fear contracting AIDS through non-high-risk behaviors.

AIDS is presently an incurable, fatal disease, so that the only means of eliminating it lies in prevention, and prevention requires abstention, safer practices in sexual and IV drug behaviors, or monogamous, nonrisk behavior relationships. In order for this to occur, all youth must be reached before they engage in high-risk behaviors or our efforts will be in vain. From another perspective, youth who already are HIV-infected require enormous amounts of support and assistance in facing the grim realities of the future.

What Do Adolescents Think, Believe, and Know And Why Is This So?

The Period of Exploration and Invulnerability

Adolescence is characterized by the need to explore many facets of life and by a sense of invulnerability, the "it happens to others, not to me" approach to life. This combination of experimentation and perceived invulnerability makes it more likely that adolescents will engage in high-risk behaviors. Kotulak (1987) noted that "doctors now refer to the new morbidity

of adolescents, recognizing that risk-taking behavior presents extremely grave health threats to teenagers" (p. 2). The Institute of Medicine and the National Academy of Sciences (1986) also noted the need to stress prevention with adolescents because of sex and drug experimentation. An interesting aspect in the adolescent's striving for adulthood is the conflict between the need for individuality and the need to behave in a manner consistent with one's peers. In order to influence young persons so that they engage in lower risk behaviors, counselors need to reach them before peer group influence has become strong and in a manner so as to encourage healthful individuality. Otherwise, their attempts to prove their individuality may result in increased risk taking.

An additional problem, often based in myth, is the attitude that, "I know how to be safe." When one looks at data on sexual behavior and on contraception use among sexually active youth, the danger of this attitude becomes obvious. In a summary of facts about AIDS and teenagers (Select Committee on Children, Youth, and Families, undated), it was reported that from 33% to 55% of teenagers surveyed in San Francisco and Massachusetts indicated that they were not worried about contracting AIDS and, in Massachusetts, only 15% of the 70% who were sexually active indicated that they had changed sexual behaviors because of concern about AIDS. The Center for Population Options (1987) reported that of sexually active, unmarried 15- to 19-year-old women, only 34% used any birth control method consistently and, of those who did use birth control, only 22% insisted their partners use condoms, leaving 78% using contraceptives offering no HIV protection. Considering the fact that over one half of all 15- to 19-year-olds (Shafer, 1987) and 70% (women) to 80% (men) of all 20-year-olds (Center for Population Options) are sexually active, the myth of knowing how to have safe sex is a dangerous one that all counselors must address.

Cultural Differences

As noted, minority youth are differentially affected by AIDS. Although cultural characteristics and attitudes vary from locale to locale, it is useful to examine some of the factors that may result in a potential higher risk for Black and Hispanic youth, because it has been documented that current informational me-

terials are not effective with these youth (DiClemente, Boyer & Morales, 1988; Fullilove, 1988; Mays & Cochran, 1987).

Many minority young men are burdened with the attitude that safer sex implies a fault in masculinity such as homosexuality or infection with a sexually transmitted disease and therefore feel that they cannot use contraceptives or maintain a monogamous relationship. Abstention might be seen as an admission that something "is wrong." Similarly, minority young women often feel that they cannot insist upon safer sex because it would be a direct insult to their partners' masculinity and health status. Such insistence could well result in ostracism for some young women because it is considered unacceptable for a woman to have knowledge about sexuality or question a man (Mays & Cochran, 1988). In a society that encourages early sexuality and "couple" behavior, this would be particularly problematic for poor or neglected youth who experience a strong need for affection and social acceptance. Because homophobia is often strong in some Black and Hispanic cultures (Peterson & Marin, 1988), the fear of being labeled gay if one is not actively heterosexual is an additional block to low-risk behavior. Seeking help is also an issue among many minority cultures, making it difficult for youth to obtain information or assistance because they might be seen as weak or as going against cultural tradition.

A similar problem may exist in Black and Hispanic attitudes toward drug abuse among urban youth. Peer pressure and a sense of hopelessness among poor youth can result in IV drug abuse in order to maintain distance from the constant negativity of life or to maintain status in the subculture. The "macho" attitude of the proof of manliness through drug abuse and the need of many young women to comply with their partners' demands further increase the risk of destructive behavior. Certainly counselors need to consider the possible effects of membership in a minority culture on both sexual and drug abuse behaviors among their clients.

Lack of Effectiveness of Educative Efforts

It has been established that current AIDS education programs are not reaching adolescents (DiClemente, Boyer, & Morales, 1988; DiClemente, Zorn, & Temoshok, 1986; Fullilove, 1988; Shafer, 1987; Shafer, 1988b, in press). Surveys and studies

of adolescents (Brown & Fritz, 1987; DiClemente, Boyer, & Morales, 1988; DiClemente, Zorn, & Temoshok, 1986; Slater, 1987) have highlighted the lack of information that adolescents possess about causes and prevention of AIDS, particularly among minority youth. The schools, which "have become a bastion of AIDS misconceptions and irrational fears" (Horan & Sherman, 1988) are ill prepared to develop and implement effective educational programs (Slater, 1988b). Yet they are the single means of reaching almost all youth. Although most adults seem to believe that youth need to be informed of the dangers of AIDS, there is great reluctance to address issues of drugs, sexuality, and homosexuality directly. Until appropriate school programs can be implemented, AIDS education will take place in a piecemeal fashion. Counselors need to direct efforts toward educating the educators and the lay public about the need for powerful, school-based programs on prevention of AIDS.

What is needed to make educative programs, regardless of where they are located, more effective?

1. They must gear materials to the developmental level of target youth. Because of adolescents' impulsiveness, experimentation, and a lack of well-developed abstract skills, materials need to be concrete and to provide ideas and techniques that permit youth to delay the immediate gratification of desires by highlighting real rewards for such delay and by making delay socially acceptable. As programs must reach downward in age so as to inform and influence children prior to the onset of high-risk behaviors, they must also be attentive to the age-appropriateness of materials.

2. They must provide current and accurate information about HIV characteristics, transmission, and prevention that convince youth of the severity of the crisis, and they must offer viable alternatives to high-risk behavior. Because information alone seldom results in behavioral change (Flora & Thorensen, 1988; Melton, 1988a), program materials must provide compelling case studies and peer-generated materials such as videos, posters, cassettes, and so forth so as to involve the youth in the educative process. An example of an effective approach was one schoolwide contest to produce rap material about AIDS that resulted in the entire school's involvement.

3. They must use language that is understood by and relevant to youth. The majority of printed materials are written for White, middle-class adults or adolescents at a relatively high language level (Jue, 1988) and are inappropriate for large num-

bers of youth in terms of understandability and appeal. In other words, they do not capture and hold the interest of the target group. Comic book material such as *Hero Comix Group: Andrea and Lisa* (Health Education Resource Organization, 1987) does seem to be a viable approach. As so clearly set forth by Mays and Cochran (1987), minority-geared material must use appropriate vernacular in describing sexual and IV drug use behaviors. Materials for Hispanic youth need to be available in Spanish and English, as, for example, *When A Friend Has AIDS* (Chelsea Psychotherapy Associates, 1984), *AIDS Hotlines* (Gay Men's Health Crisis, 1986) or *Straight Talk About Sex and AIDS* (San Francisco AIDS Foundation, 1986).

4. They must address the needs of minority youth in terms of cultural attitudes, beliefs, traditions, and values. In order for this to happen, minority persons need to be involved in the development of such materials and, prior to distribution, all such materials need to be evaluated by panels of minority youth to determine relevance and appeal.

5. They must address drug abuse, sexuality, and homosexuality directly without evoking strong community resistance. This requires emphasis on protecting the lives of youth, not on encouraging behaviors that threaten the community by going against mainstream society. Youthful abstinence probably will need attention whether or not the counselor believes in its appropriateness or reality. Keep in mind that a program that has been banned or canceled cannot assist anyone.

6. They must offer treatment options or recommendations for those youth who need mental health support or treatment. This aspect of the program needs to allay anxiety and overcome resistance to seeking counseling.

Major Issues Adolescents Face

"Catching" AIDS

Contracting AIDS is a concern of many youth, although not as many as one would expect. Among those with whom counselors will have contact are the "worried well." Because these youth often are not engaging in high-risk behaviors, counselors need to assess the reality factor in each case. With young gay men, because of the possibility of transmission of the HIV

through anal or oral sex, anxiety is realistic unless a young man has never engaged in these sexual behaviors and the youth intends to follow safer sex practices. IV drug abusing youth also have realistic anxiety. If a youth is at low risk, AIDS-related counseling needs to attend to overall high anxiety aspects of personality development, with concomitant provision of clear information on HIV transmission and prevention and with reality testing of the interface between actual behaviors and risk factors. One will usually find evidence of many other anxieties in these youth.

Passive transfer, contracting the HIV without engaging in any known high-risk behaviors, has both realistic and unrealistic aspects. Among the most realistic factors are pre-perinatal transfer from the infected mother to the infant, and blood or blood factor transfer through transfusion prior to the initiation of blood testing. With an unknown latency between infection and onset, there certainly are youngsters who have become infected but are asymptomatic. If there is a strong possibility of infection, (e.g., a high-risk mother, transfusion after a trauma, hemophilia, etc.), this author believes that it is wise to recommend and to assist in obtaining anonymous (not confidential) antibody testing, with a repetition of the testing in 6 months if the first results are negative. It should be noted that others do not espouse this point of view, and some feel that the dangers to the client of testing outweigh the benefits (Coates, Stall, Kegeles, Lo, Morin, & McKusick, 1988). Of course, should a positive result be obtained and verified through additional evaluation, counseling will take on an entirely different character and require intensive work. A negative result can be used to reassure, except in rare circumstances (Goldblum & Marks, 1988), *provided* that there have been no high-risk aspects for several years and that no high-risk behaviors are engaged in from the time of the original antibody test.

Unrealistic factors are usually based in the myths promulgated widely in society as to the dangers related to casual or daily living contact. Although the literature has made it clear that AIDS is not transmitted by insects, by toilet seats, by physical, nonsexual touch, by sharing eating implements, by sharing the same classroom, by living together, and so forth (Centers for Disease Control, 1986; Committee on Infectious Diseases, 1987; Fischl, Dickinson, Scott, Klimas, Fletcher, & Parks, 1987; Friedland et al., 1986; Friedland et al., 1987; Koop, 1986; Slater, 1988b), these myths continue to abound. As in the case of

the low-risk, "worried well" youth, information developed specifically for youth, such as *AIDS: You Can't Catch It Holding Hands* (de Saint Phalle, 1987) and *Understanding and Preventing AIDS: A Guide for Young People* (Colman, 1988) can be of assistance in developing healthier attitudes.

Active transfer, becoming HIV-infected through engaging in high-risk sexual or IV drug abuse behaviors, is of great concern to a number of youth, both gay and heterosexual. Among all of the clusters of persons vulnerable to HIV infection, including everyone except those who are celibate, who do not abuse drugs, or who are in monogamous, nonrisk relationships, the most distinctive behavioral changes have been made in the gay community. Because of intensive educative campaigns, gay youth who have been able to benefit from these efforts are now more likely to follow safer sex practices, thus reducing risk. However, counselors will have their hands full working with all youth who endanger themselves through risky behavior, including gay youth who have been unable to avail themselves of information about more reasonable behaviors, IV drug abusers, and heterosexual youth who have had sexual or IV drug contact with infected persons.

The Emotional Impact of AIDS

Another issue young people face is the emotional impact associated with knowing or hearing about others who are HIV-positive, who have AIDS, or who have died of AIDS-related opportunistic diseases. As a result of the long latency period, it is less likely that adolescents will personally know persons with AIDS. However, counselors must be prepared to deal directly with this issue when it does occur. Youth who know of a peer who is HIV-positive will need to resolve the possible fear of contracting AIDS from that peer, the shock of perceiving the peer in a different light, and the issues surrounding death and dying. If the affected person is a relative, particularly one close to the youth, the same issues will evolve but with death and dying aspects heightened. In addition, if the youth has not had a good relationship with the affected person, guilt over not having behaved in an "appropriate" manner may be felt.

When youth become aware of a person with AIDS who is known to them in a way not mentioned above, the reaction can vary markedly from horror and fear, as in the case of a well-

liked teacher, to curiosity, as in the case of a well-known public figure. The more attention given by the media, as in the case of an actor or athlete, the more likely that curiosity will be present without extreme fear. If the noted person has died, stronger feelings are apt to be evoked.

In any of the situations noted, strong reassurance and support are called for. If the youth has incorrect information leading to the escalation of anxiety and fear, information is also warranted. It is strongly suggested that counselors, and others, be prepared to present programs to the youth and staff of a school, church, social athletic organization, or any other formal program should a person who is connected to that setting die of AIDS-related conditions or become incapacitated because of AIDS. If the affected person continues normal activities, then youth may need to be encouraged to treat the individual as they would anyone else if problems about AIDS arise.

Homophobia and AIDS

Homophobia as it relates to AIDS affects many gay and lesbian youth. Homophobia, defined as "the recognized or unrecognized fear or hatred of homosexuality or homosexuals that is present in both heterosexuals and homosexuals" (Slater, 1988a, p. 227), has been attached strongly to AIDS. In turn, this has resulted in an escalation of prejudice against, rejection of, harassment of, and attack on gays and persons suspected of being gay (Altman, 1986; Berrill, 1985), thus increasing young gay men's fears of coming out.

Although it is clear that gay men are the highest risk group and young men must face this fact, it is equally clear that being gay does not mean that one is infected. Counselors will need to work intensively to repair the damaged self-concept of many young gays who have come to see themselves as degenerates or evil because of society's messages. These negative self-perceptions make it extremely difficult for young gay men to seek either information or counseling because of a fear of being seen as "sick" by the counselor.

Of extreme concern is the pain closeted gay youth face who are HIV-positive and who must deal simultaneously with a life-threatening condition and coming out to important others. These youth require even more massive support and assistance than youth who are already open to family and friends. Bibliotherapy

is useful, particularly the form that provides materials for reading and then uses the obtained information as a springboard for therapy discussion. Because of the difficulty of youth in obtaining appropriate material on coming out and on AIDS, both from a cost perspective and from the perspective of having to enter a gay/lesbian bookstore to obtain these materials, it is recommended that counselors develop libraries of books, pamphlets, articles, audiotapes and other materials for loan purposes. Public and school libraries are sadly lacking in current, relevant books. As has been noted, the gay community has been most effective in developing resources related to AIDS. It is, therefore, recommended that counselors maintain strong liaisons to gay organizations in their area so that direct referral of youth to the most appropriate supportive programs and resources can be accomplished quickly and easily.

Therapy Aspects

Although many aspects of therapy apply across a variety of youth, it is useful to explore aspects that are particularly relevant to specific populations. Among these populations are adolescents in general, high-risk adolescents, and adolescents who are HIV-positive, who have ARC, or who have AIDS.

Youth in General

In counseling all youth, AIDS ought to be an integral part of the process so as to reduce the potential for risky behaviors. Obviously this aspect of counseling can take place only in the overall context of counseling and cannot be allowed to interfere with crisis situations. Often youth have not had the opportunity to discuss their fears, thoughts, and attitudes about AIDS and so will welcome a safe and open ground for such discussion. Certainly the provision of information about disease characteristics and prevention can be accomplished in a straightforward manner, taking into consideration those aspects noted in the section of educational efforts. Time needs to be spent on the demystification of AIDS so that youth can develop a more realistic view of AIDS.

Anxieties related to AIDS most probably will need to be integrated into the overall fabric of anxiety characteristics in

the individual counselee. As has been noted, low-risk, "worried well" youth frequently are high-anxiety individuals, so the counselor will be working with anxiety as an overall personality factor.

In order to effect low-risk behaviors, counselors may wish to consider what means will be most effective to build confidence in the self while concomitantly lowering the sense of invulnerability. As an aspect of impulse control, it also will be helpful to assist in the development of a sense of being able to deal effectively with one's needs in a reasonable and safe manner. Part of the movement toward safer behaviors is the building of a network of peers and adults upon whom the youth can rely when he or she needs to talk about intimate issues, and a counselor can implement this growth process.

High-Risk Youth: IV Drug Abusers

All of the ideas presented in the previous section are useful in working with IV drug-abusing youth. In addition, preparation for entry into a drug program is essential, as it is unlikely that a drug-abusing youth will be able to give up a drug habit without the intensive support provided by such specific-intent programs. It is common for these youth to experience isolation and feelings of unworthiness so that counselors will need to work toward alleviation of the negative self-image and building up of an appropriate support network if the youth is to be able to even consider cessation of self-destructive behaviors associated with drug abuse.

High-Risk Youth: Gay Men and Lesbians

Again, all of the ideas noted in the section of youth in general are useful. In addition, treatment of gayness or lesbianism as an essentially normal variation of life is critical. If this is to succeed, it must take place in a low-homophobic counseling environment so as to permit the development of trust in a safe adult. Obviously, because so many youth are in the pre-coming-out process either to themselves or to others, counselors must present a low-homophobic profile to all youth. A counselor never knows when the youth sitting in the other chair is gay or lesbian. If the young person is aware that homosexuality is not seen as bad, evil, or sick, it then becomes possible to explore his or her orientation and to come out to the counselor.

Once it has been established that the client is gay or lesbian, issues related to homosexuality and AIDS can become a part of the counseling. It needs to be clearly stated here that a gay or lesbian status should never be considered to be the problem. It needs equal emphasis that being gay or lesbian has its own difficulties because of the typical negative messages transmitted throughout society about homosexuality. Although a young gay man or lesbian most certainly may have problems associated with orientation, it is the beliefs and attitudes, not the orientation, that cause difficulties. Provision of information related to being gay or lesbian ought to include objective and accurate facts about homosexuality, coming-out processes, developmental stages, forming relationships, and the development of support networks in the community (Slater, 1988a). Once again, bibliotherapy is one of the most useful educative aspects of counseling with lesbian and gay youth.

Although lesbians are discussed here, they are in the next lowest risk group following non-drug users, sexual celibates, and those in long-term monogamous and nonrisk behavior relationships. However, it is important to communicate to young lesbians that they are not protected from AIDS and to discuss with them how the HIV can be transmitted to lesbians who have partners who are IV drug abusers, are bisexual, or have had relationships with high-risk lesbians. The rather down-to-earth saying that one goes to bed with everyone with whom the partner has had sexual or IV drug abuse contact is accurate. Safer sex practices ought to become a part of counseling with young lesbians.

Clients who are young gay men face many more frightening possibilities than do most lesbians. Harassment and violence have been more strongly directed against gays, although it is clear that lesbians also experience both. The possibility of being harmed because of one's orientation typically leads to anxiety, fear, and anger. All of these reactions need to be dealt with in the counseling environment, which becomes a safe place to ventilate and then work through the anger and frustration associated with society's inappropriate reactions toward the youth. Gay youth who come out often face rejection by peers, family, and important others. Sometimes this rejection is temporary, but it can be permanent. This needs to be taken into consideration when one is assisting youth in determining whether to come out and, if so, to whom, when, and how. A counselor must be realistic in discussing possible reactions of key persons

in the youth's life. AIDS has added another dimension to this issue because so many individuals associate homosexuality and AIDS in a manner that escalates negativity toward the target youth. Counselors ought to be prepared to act as major support persons in the lives of their coming-out youths and to devote serious efforts toward alleviating the negative self-concepts that develop as a result of rejection. The concept of a second-chance family, originally developed by Malamud and Machover (1965), can be brought into play here as the youth is encouraged to develop a supportive network or current family similar to an ideal family.

Providing information about safer gay sexual practices is, of course, a part of any counseling with young gays, although it may not be able to be brought into the situation until more pressing issues have been dealt with, at least to the extent that crises have been reduced to a tolerable level. This information must be concrete and graphic if it is to be of use. As previously noted, open young gay men already may have benefited from the educative materials developed by gay organizations so that counselors can build upon that knowledge. In the case of coming-out or closeted youth, the counselor may become the key figure in information development. It is suggested that counselors follow the lead of clients in the use of sexually relevant terms, concepts, and phrases. This means that counselors must carefully inspect their own biases and comfort related to sexuality before attempting to discuss sexuality with clients, particularly with gay youth. If the client has not developed a language, then it will be necessary for the counselor to assist in the development of a working vocabulary before the process can proceed further.

Youth Who Have AIDS, Who Have ARC, or Who Are HIV-Positive

Primary to treatment is the provision of an accepting, non-fearful atmosphere in which the young person can receive the massive support and caring necessary for infected individuals. In order to handle this, counselors will have to examine their own responses to AIDS and, perhaps, receive assistance in attaining a comfortable stance. Although all persons might to respect and fear the HIV, it is not necessary to fear HIV transmission from a client.

Development of an understanding of the meaning of being HIV-positive, of having ARC, or of having AIDS requires the

ascertain the legal and ethical situation in their locales and to apprise counselees of the limits of confidentiality that exist or that the counselor assumes exist. The issues of legal or ethical responsibility need to be considered apart from the counselor's estimate of the desirability of bringing others who may be affected by the counselee's status into the counseling situation.

For youth with AIDS, one of the primary responsibilities of the counselor will be leading the youth through the stages of initial crisis, early adjustment or the transitional stage, acceptance or the deficiency stage, and preparation for death (Nichols & Ostrow, 1985; Stem and Cohen, 1986) effectively discussed therapy related to these stages. Loss of three varieties that can be labeled as "loss of control, loss of the sense of identity, and loss of relationships" (Hidalgo, Peterson, & Woodman, 1985, p. 776) will also consume considerable counseling time. Because of the deterioration typical of AIDS, work will need to be rapid if it is to help the youth, and the counselor will need to be prepared to work with a person who changes rapidly in terms of physical and mental functioning. Dealing with potential suicide and sexual acting up may also become part of the treatment.

Because rejection is so typical, the counselor may become the client's emotional parent, lover, friend, and educator, and therefore, will experience enormous drains of energy and problems of responsibility. It is strongly recommended that any counselor working with AIDS youth develop a strong professional and personal support network so that issues related to the counseling can be resolved. Counselors also ought to anticipate that they will be with the youth until he or she dies so that preparation for the anticipated deterioration and impending death must be undertaken. It is recommended that focus be placed on developing new support systems or strengthening already existing support systems for the youth. Where family are available, including the affectional partners of the youth, counseling will need to include these important persons.

Counseling Techniques

Counseling techniques related to AIDS should be integrated into most theoretical frameworks with some necessary changes to account for the unique characteristics of AIDS counseling. Counselors may need to alter their theoretical perspectives to be more

ability of therapy as we know it to be effective, and be willing to move ahead even with this knowledge.

Summary

Work with HIV-positive youth is compounded by the tendencies of adolescents to explore sexuality and to see themselves as invulnerable. It is clear that current educative efforts are not effective, particularly with minority youth. Youth face issues of the "worried well," fear of passive or active transmission of the HIV, the emotional impact of AIDS, and homophobia. Counseling must address the needs of youth in general, IV drug abusing youth, gay and lesbian youth, and youth who are HIV-positive and nonsymptomatic, who have AIDS-related complex, or who have full-blown AIDS. Although there is no preference of one technique over another, speed is essential, the educative aspects must be addressed, the counselor must provide massive support, and the counselor must have an adequate support system.

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Chapter 6

DOUBLE INDEMNITY: SUBSTANCE USE AND AIDS

Eel Knapp Duncan and Carol Knapp Duncan

The use of mood-altering substances has expanded in the U.S. population in the last 25 years to the point that it is estimated that the disease of chemical dependency is a struggle for 10% of heterosexual adults (ages 17–75) and for one third of gay and lesbian people (Finnegan & McNally, 1987). These 25 million citizens combine with 5 million intravenous drug users (Gregorio & Linden, 1988) to constitute a primary AIDS risk group of 30 million.

According to Centers for Disease Control data (1988, January), at least 48% of people with AIDS had a drug abuse history. Of these, approximately 50% are gay and bisexual men who use intravenous drugs and almost 25% are heterosexual IVDUs. In examining these figures, it is important to recognize that CDC statistics tend to minimize the crucial issue of dual diagnoses. Because people with AIDS are listed in CDC statistics under only one risk category, people who are gay *and* substance abusers or bisexual *and* IVDUs are not accounted for as such, despite the recognition that these combined diagnoses are glaring prevention and treatment realities.

By 1992, the Public Health Service predicts that AIDS will be the number two killer of U.S. citizens after cardiovascular disease. This increase in cases can be altered by effective health-promotion, risk-reduction, and disease-prevention programs. The effectiveness of the major programs will be proportional to the degree of cooperative planning among community AIDS

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counselors, public health planners, and treatment program staff. This chapter addresses issues unique to counseling people whose use of mood-altering substances puts them and others at higher risk for HIV disease. The chapter begins by examining general characteristics of the substance-using population. It then turns to a profile of the HIV-infected substance user and the recovery process. The chapter continues by discussing ways in which the HIV virus is transmitted within the using population and from the using population to the nonusing population. Finally, the chapter examines counselor interventions, describing both assessment and counseling techniques.

The Substance-Using Population

Although IVDUs constitute the second largest group (after gay bisexual men) of CDC-defined AIDS cases, when they are coupled with those whose chemical dependencies render them incompetent to practice safe sex behaviors, the aggregation swells to a risk group larger than that of gay bisexual men. Although it has been documented that HIV prevention behaviors have reduced new HIV seroprevalence to less than 1% in the gay bisexual community (Winkelstein et al., 1988), chemically dependent IV drug users are still at risk. The AIDS risk-reduction message has not reached drug users with the same impact as it has reached gay and bisexual men. Many counselors and epidemiologists consider substance users to be the "second wave" of the AIDS epidemic.

The substance-abusing population forms a less solidified community than the gay community and thus is less easily accessed for education and prevention purposes. Substance-abusing subcultures do exist. These subcultures often depend on the drug of choice; methamphetamine users, alcoholics, crack smokers, heroin shooters, and cocaine sniffers each may have their own "culture." In areas where many users live, work, and play—for example, urban settings—there will be hierarchies and divisions among users; where there are fewer overall users, there may be more of a passing congregation based on getting high regardless of the substance used. Counselors may find it helpful to view drug using as a behavior that occurs within a particular drug-using culture, rather than viewing drug use simply as a matter of individual pathology.

Drug-using behaviors that put users and their sexual partners at risk for HIV can be understood through the help of ethnography, a science that studies the cultural context (Feldman & Biernacki, 1988). From ethnographic observations, one sees structured sets of roles, values, and status allocations in a previously described "difficult-to-access" population. Rather than being viewed as different, as objects of scorn, fear, hostility, mistrust, and pity, the drug-using population might be considered to be people who do not follow societal expectations as defined by current public policy. Securing and using drugs constitutes a game played between drug users and representatives of the social control system such as the police and the legal system.

The substance-using population, especially IVDUs, tend to distrust much of what they hear, particularly from authority figures. Communication barriers can exist because of ethnic, cultural, and educational differences. Health educators often speak in coded, jargon-laden phrases that sound foreign to substance users at risk for HIV disease, many of whom have low self-esteem and are not motivated to try to understand or remember the message.

Access to health care is a major issue for this population. Substance abusers tend to have an irregular employment history, resulting in a lack of health insurance. If users who are HIV-seropositive do have insurance, they are hesitant to use it for drug treatment program coverage for fear that their confidentiality will be breached or the policy will be canceled. If an individual (regardless of "use status") is between 18 and 55 years old, he or she has a 25% chance of having only Medicaid coverage, which provides minimal services.

Many members of the drug-using population first identify as marginalized citizens dealing with the social legacies of classism, sexism, racism, and homophobia. Compared to the lack of decent and affordable housing, high infant mortality rates, limited educational opportunity, limited job training, institutionalized discrimination, easy availability of handguns, and high teenage pregnancy rates, the threat of AIDS, with its 11-year incubation period, does not seem to warrant much concern.

Other users do not consider themselves marginalized citizens; they are often called "white collar" drug users. College students tested for HIV disease are reported to have approximately half the seroprevalence rate of those in the prison system. This suggests that education and money do not motivate

white collar drug users to use condoms more, to share needles less, or to seek treatment more frequently. Instead, these users may be more skilled in denial, bargaining, and intellectualization. Although their manipulative behaviors and verbalizations may be more difficult for health care professionals to deal with, white collar drug users are often able to look at their chemical dependency and increased risk for AIDS. Ramm (1985) and Sorenson and Bernal (1987) offered ways in which counselors can encourage their clients to examine drug use patterns.

HIV-Infected Substance Users and the Recovery Process

The statistics of reported AIDS cases reveal that of the almost 20% of heterosexual IVDUs, 78% are men and 22% are women. Blacks compose 50% of this group, Hispanics Latinos about 30%, and Whites about 20%. Blacks and Latinos continue to be overrepresented among IVDUs with AIDS as compared to IVDUs in general. These statistics come predominantly from New York, Connecticut, and northern New Jersey where three quarters of all IVDU–AIDS cases originate (Des Jarlais & Friedman, 1988). However, in those states, Whites constitute a smaller proportion of IVDUs than in the remainder of the country.

Of those people who have been diagnosed with HIV disease since the beginning of the epidemic, one half are dead. The others survive with the realities of harboring a chronic, usually fatal virus. If the infected person is a substance user or IVDU, he or she will probably interact with the AIDS health care delivery system or the substance abuse treatment system. Often this involves seeking access to limited resources and facilities. As a result, many continue to live in denial of their substance abuse and without knowledge of their HIV serostatus. Some lower income seropositive IVDUs attempt to "spend down," exhausting what little financial resources they have in order to qualify for public health services. Others continue life on the streets or find temporary housing in the limited shelters for the homeless, which often lack proper medical treatment.

Recovery

The user who is HIV-positive and has had knowledge of his or her serostatus for several months may express a readiness

for recovery from his or her addiction in the hope of receiving better health care. The concept of "kairos," a potential turning point or opportune and decisive moment, is often used to refer to this expectant and fragile time. Early indicators in persons about to stop using drugs or about to enter a treatment program have been identified. The authors' experiences and those of Biernacki (1987) point to a number of categories of presenting issues that people often express at the beginning of the recovery process. Knowing these "pathways from addiction" may be helpful to counselors working with HIV-infected substance users.

A first pathway from addiction involves the user's "hitting bottom," or acknowledging that there is too much pain in their life. A "bottom" with IV users could be collapsed veins, or a significant accident such as an overdose. Other users may experience intolerable self-blame or feel overwhelmed by their HIV infection. Although bottoms are of all types, most can be framed as decreases in coping mechanisms.

A second pathway may be initiated when a significant other leaves. This could take the form of the death of a partner from AIDS, a loss due to incarceration, or the end of an emotionally supportive relationship. Sexual dysfunction may become pronounced or sexual phobia may enter the relationship as a result of the partner being HIV-seropositive. The "significant other" could be the user's drug-using friends (his or her "running buddy" or "copping partner"), or even the drugs themselves. The loss might result from the user's drug supplier becoming sick or getting arrested. This large category acknowledges the interaction and interdependence (even codependence) of the user and others in his or her social networks.

A third pathway occurs when users seem to mature out of their habits; they recognize that they are aging. Particularly in HIV-infected users, there may be an extremely disturbing decline in general physical health and appearance. Other users may simply desire more stability in their lives as they reach 30 or 40 years of age. Recent work with female users suggests that women may be more responsive to maturation effects than men (Murphy, 1987; Murphy, personal communication, 1988).

A fourth pathway involves a personal existential crisis, common in the face of the AIDS epidemic. Occasionally a significant visionary or conversion experience is reported. Suicide attempts and some overdoses fall into this category. Increased religiosity or even moral self-ostracism from the using population can put the user into kairos. Being hospitalized for an opportunistic

infection may offer the user a more contemplative environment that could foster an idiosyncratic and self-identified crisis and result in a desire for drug recovery.

The Spread of AIDS

The spread of AIDS in the substance-abusing population occurs via two primary vectors. Substance abusers transmit the HIV virus to other abusers through the use of blood-contaminated needles. In addition, as with other populations at risk for AIDS, substance users spread the HIV to other drug users and nonusers alike through unsafe sexual practices.

Spreading AIDS Through Unprotected Sexual Practices

As with other populations at risk, AIDS in substance users is spread through unsafe sexual practices. In 1988, Feldman, Biernacki, and Knapp-Duncan conducted extensive interviews with 295 IVDUs in San Francisco who were identified through chain referral and targeted sampling (Watters & Biernacki, in press). Of this group, 70% of the drug users believed that AIDS can be transmitted sexually to and from partners. However, despite their knowledge, only 42% acknowledged using condoms or other types of latex protection. This figure is alarming in light of the fact that 81% of these IV drug users reported having had sex with at least one person in the preceding 6 months. Although the HIV status of this specific group of IVDUs was not specifically known, blood testing of overlapping samples in the same neighborhoods yielded a 15% seroprevalence rate (Watters, 1987).

Substance abusers who do not shoot drugs intravenously are *not* free from the risks for AIDS. The primary risk to these non-needle-using substance users is from disinhibition because of their substance-induced "high." The euphoric and disinhibited feeling during alcohol or drug use affects the user's judgment, "allowing" the user to engage in high-risk sexual acts despite the knowledge of AIDS risks.

and "rigs" or "works" between users and users. Needle hygiene among IVDUs is reported to be used only 75% of the time after 2 years of an innovative, street-based outreach program (Feldman & Biernacki, 1986, 1988; Watters et al., 1988). Needle hygiene behaviors among IVDUs in cities other than San Francisco are much less frequent (e.g., Des Jarlais, Garrett, & Friedman, 1988; Becker & Joseph, 1988).

The previously discussed Feldman, Biernacki, and Knapp-Duncan studies in 1988 found that intravenous drug users were more careful with regard to needle hygiene than to safer sexual practices. Most of the sample of IVDUs (70.2%) reported never reusing "rigs" without cleaning them. These results replicate and extend those of Watters (1987), who reported that needle cleaning among a sample drawn from the San Francisco IVDU population rose from 30% in 1986 to 76% in 1987. In contrast, the use of condoms was reported to have increased only from 25% to 31% during that year (Watters). This suggests the existence of a greater resistance, at least among the IVDUs in San Francisco, to practicing safer sex than to implementing clean needle hygiene. Counselors who are mindful of the above data can structure their clients' risk assessment around unprotected sexual risk (including perinatal) as well as the more direct risk from shared needles.

Assessment

Counselors working with both substance *using* and substance *abusing* clients will want to assess them clients for the risk of exposure to the HIV. In addition, counselors will want to take an inventory of how receptive these clients are to implementing of the behavioral changes that AIDS prevention methods demand. Counselors will need to assess the amount of information about AIDS and the transmission of the HIV that clients have. They will also need to be aware of any limits to the amount of new information clients are able to incorporate into their lives. Counseling clients with a high probability of risk for AIDS is most effective when it is built on some type of plan that incorporates client history. Clients' risk levels must be assessed near the outset of treatment either by semistructured interviewing or by an instrument such as AIDSRISK (Polaris Research & Development, 1988).

The AIDSRISK instrument has three components: a quantifiable risk assessment questionnaire, a counselor case record and counseling issues planning guide, and an extensive, 200-plus page counselor manual. This manual provides detailed guidance for counselors in the planning and delivery of risk reduction counseling. AIDSRISK is appropriate for people of all ages, for gays and lesbians, and non-gays and non-lesbians alike. The instrument has separate scales for men and women. The risk assessment results from AIDSRISK are compiled in an easy-to-understand "thermometer" that visually communicates the estimated level of risk.

Counselors using a nonstructured assessment interview should include questions related to past risk behaviors such as unprotected sexual activities, intravenous drug use, "recreational" or other drug use, and use of blood products, including transfusions. It is best to get a 15-year history. It will be useful for counselors to be sensitive to a client's family history of substance use and abuse, and any evidence of sexual abuse. Although each counselor's clinical judgment should guide the inquiry and his or her personal style should dictate its framing, the authors advocate an informal, but not client-centered, approach with drug-using clients.

Counselors will also want to assess their clients' openness to the changes necessary to implement safer sexual practices. In large part, the drug- and alcohol-using community operates around short-term goals, not long-term disease prevention plans. Clients' attitudes toward nicotine, smoking, and lung cancer might be explored as a means of assessing their capacity to understand and incorporate long-term changes. Similarly, counselors can explore clients' attitudes toward caffeine, dietary salt, or sugar as a general indicator of the clients' health consciousness. If the using client can understand, through the assessment sessions, the value of longer term health goals, then major behavioral changes may be possible. If clients' immediacies or basic needs are paramount, then perhaps the biggest gift a counselor can give them is to expand his or her professional role to that of a superbly knowledgeable referral source (Kagle, 1987) and to keep clients coming back—or go to them.

Assessment also needs to be made of the client's knowledge of HIV and its transmission. Although much of this may already have been addressed during history-taking, any areas that were not covered should be focused and elaborated on, especially facts about HIV a particular client needs to hear. This assess-

ment might include the discussion of topics such as the pros and cons of HIV antibody testing, confidential testing versus anonymous testing, and the value of testing as a part of an overall strategy for health promotion, risk reduction, and disease prevention.

Often the counselor is tempted to impart far more information than the client is willing or able to incorporate into his or her life. This kind of overeducating through talk may relieve the counselor's anxieties, but may not be appropriate for the client. Many clients may not be psychologically capable of directly dealing with even factual information about AIDS at initial sessions with counselors; pamphlets are often helpful for later reading. Counselors need to remember that information about AIDS is not a sufficient intervention. Tools for behavior change are critical components of an effective strategy. These tools include needle detox or treatment programs, bleach or easily usable containers, and needle exchange programs (Des Jarlais & Friedman, 1988).

Implications for Counselors

Successful AIDS counseling programs for substance abusers have four basic components. Cognitive, attitudinal, behavioral, and environmental factors are all integral parts of AIDS prevention with drug users. Table 1 delineates a variety of specific issues that influence AIDS prevention efforts with IVDUs. These components and factors must be incorporated in counselor education programs in order to be effective.

Cognitive components of successful counseling programs for substance abusers address the amount of knowledge they have about different AIDS-related issues. Education geared toward cognitive change must instruct substance abusers on AIDS transmission, needle hygiene, and safer sex practices. Counselors must also provide substance users with locations, directions, and phone numbers for local drug treatment centers as well as health and social service agencies.

Attitudinal components of successful counseling programs for substance abusers examine the beliefs, attitudes, and values substance abusers hold that may prevent them from stopping the spread of AIDS. Counselors will need to address factors that motivate clients to adopt a healthy life style. Counselors

TABLE 1

Components of Successful AIDS Prevention, Education, and Counseling With Substance Abusers

Cognitive
- Knowledge of AIDS and its means of transmission
- Knowledge of needle hygiene
- Knowledge of safer sex practices
- Knowledge of drug treatment and other local health and social service resources

Attitudinal
- Motivation to maintain/promote health
- Beliefs about riskiness of one's practices
- Attitudes about self-efficacy
- Values about sex, sexual practices, and procreation
- Self-esteem
- Esteem for peers as models/influencers
- Attitudes about health and human services agencies

Behavioral
- Drug user profile
- Needle-sharing hygiene practices
- Sexual practices
- Language and literacy
- Basic life skills
- Use patterns of health and human services, including drug treatment
- Residency
- Job skills and employment history

Environmental
- Drug use patterns
- Hangouts
- Systematic connections between substance-using groups
- Law enforcement practices
- Availability of housing and employment opportunities
- Access to health and human services agencies
- Access to AIDS service organizations
- Access to community-based organizations

will need to review clients' beliefs about the riskiness of sexual practices. At the same time, clients' values about sex, sexual practices, and procreation must be taken into consideration. Clients' self-esteem and their perception of self-efficacy are also attitudinal considerations of successful counseling programs.

Finally, how a substance user views peer educators and health and human service agencies needs to be addressed.

Behavioral components of effective counseling programs with substance users focus on eliciting changes in risky and unhealthy behaviors. Needle sharing, needle hygiene, sexual practices, and basic life skills are target areas for behaviorally oriented counseling. Enhancing clients' job skills and helping clients find housing also fall under this category.

Environmental components of successful AIDS counseling programs for substance users take into account the influences that various patterns, locations, and cultural factors exert on substance users. Counselors will need to address ways that recovering substance users can break away from old hangouts, old drug-using friends, and old illegal activities or patterns. On a broader scale, environmental components of successful counseling programs involve making resources available to HIV-infected substance users. Counselors need to become active in legislation and other activities that will help establish health and human service agencies, AIDS service organizations, and community-based organizations equipped to handle the special issues of HIV-infected substance abusers.

Many clients may initially approach counselors seeking only accurate information on AIDS. As counseling progresses, other issues may arise such as death and dying, spirituality, coming out, and recovery. AIDS issues are often a client's presenting concerns that seem to touch all areas of his or her life.

Whether counselors serve in institutional settings, familial settings, in clerical or pastoral settings, or in a "street" setting, their most effective tool will be a nonjudgmental attitude. AIDS counseling with substance abusers demands that counselors drop their professional veneer; it encourages counselors to be neighborly and natural and to be more personally open than usual. Regardless of what counselors see and hear of marginally legal or even illegal drug activity, they must make AIDS prevention their primary focus.

As mentioned in Table 1, counselors need to incorporate culture-specific values, norms, attitudes, and expectations to produce useful services (Peterson & Mann, 1988). The using population varies by ethnic group, by sexual orientation, and by neighborhood norms. Counselors will talk with members of conventional and, more often, unconventional families of substance users.

It will be helpful for counselors to identify in some way with the substance abusing population. One way counselors can facilitate their own identification with substance abusing clients is to go through the process of self-inquiry. Counselors can examine their own position in today's success-driven, upwardly-mobile, more-is-better, avaricious society. Counselors can recall their own failures, their own personal "bottoms." Counselors can remember what it felt like when they had no trusted social support system. Counselors will grow professionally and personally by confronting these issues as they work with substance using populations (McKusick, 1988).

Conclusion

Substance users compose a population severely affected by AIDS. Substance users contract AIDS through two primary routes of HIV transmission: the use of unclean intravenous needles or other blood-contaminated drug apparatus and unsafe sexual practices. Substance abusers who are also HIV-infected must contend with dual stigmatization. Counselors working with such clients will have to attend to both recovery issues and AIDS-related issues. In light of the prevalence of HIV infection in the substance-using population, counselors will want to undertake some type of AIDS assessment with most of their drug- and alcohol-abusing clients. Counselors will need to be conscious of cognitive, attitudinal, behavioral, and environmental factors unique to the substance-using population as they engage in the valuable task of helping clients confront the problems of substance abuse and AIDS.

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Chapter 7

CULTURALLY SENSITIVE AIDS COUNSELING

Sally Jue and Craig D. Kain

Many consider acquired immune deficiency syndrome (AIDS) to be a White gay male disease. This view is reflected in the portrait of the "typical" person with AIDS in the AIDS education and prevention materials written primarily in English, and in the lack of culturally sensitive health and social service agencies specializing in AIDS. This stands in stark contrast to the facts: There is a disproportionate percentage of AIDS cases among Blacks and Hispanics compared to their percentages in the general population (Heyward & Curran, 1988).

Mays (1988) suggested that before AIDS prevention efforts can be truly effective it is important for counselors to know the issues intimately associated with everyday-life realities of overlooked or misunderstood populations, the same holds true for effective counseling. This chapter examines AIDS issues from a culturally sensitive perspective—a perspective that honors and respects the diversity of all clients regardless of ethnicity, minority standing in society, or lowered socioeconomic level. After considering general issues in culturally sensitive counseling, issues for minority clients at risk for AIDS are presented.

The Culturally Sensitive Counselor

Culture can be defined as attitudes, values, and beliefs that influence self-perception, self-expression, and perceptions of others. Whether born in this country or elsewhere, ethnic minority people retain, in varying degrees, aspects of their culture and language. In addition to differences between minority cul-

tures and the majority culture, differences exist within each minority group. For example, Hispanics come from many countries in Central and South America and the Caribbean in addition to those born here. Asians, both those born in the United States and those who have immigrated, represent over 100 languages and dialects from nearly 30 countries and territories. Black Americans who are raised in the urban North differ from Blacks raised in the rural South and those who have emigrated from the West Indies and Africa. Each group has diverse ways of expressing themselves, diverse ways of coping with problems, and therefore diverse ways of meeting their needs. Given the diversity both between these groups and among these groups, counseling interventions appropriate for White Americans will often be inappropriate and ineffective.

Often counselors are unaware of how culture influences their interpretations of behavior and thus the outcome of counseling. Often clients, as well, are unaware of these influences. Counselors working with ethnic minority clients with AIDS and their families must have an understanding of their clients' cultural values and how these values influence behavior. An exploration of cultural differences through open discussion can be beneficial to both the client and the counselor. The client, with the counselor's assistance, will need to explore and distinguish between what are cultural issues and what are personal issues. Through understanding and supporting sexual or ethnic differences, the counselor can alleviate confusion, facilitate the breakdown of internalized negative stereotypes in the client, and help raise the client's self-esteem. Providing positive cultural reinforcement for Blacks and Native Americans is especially helpful because American society has a long history of destroying its original culture. For a counselor to support the differences between cultures, he or she must be sensitive to the impact of culture on the counseling process. Counselors, particularly those doing AIDS work, will need to expand their skills and knowledge in order to incorporate concerns raised in at least four areas: stigmatization, traditional cultural healing methods, cultural views of counseling, and the role of the therapist.

How Does a Group Handle Stigmatization?

AIDS is a stigmatized illness. Herek and Glunt (1988) assert that persons infected with HIV must bear the burden of societal

hostility at a time when they are most in need of social support and that "attempts to avoid such hostility may compromise an individual's health" (p. 880). Because in America the disease of AIDS has been socially defined as a disease of marginalized groups, the stigma attached to AIDS as an illness is layered upon preexisting stigma (Herek & Glunt).

To obtain a better understanding of an individual client's response to AIDS, counselors will find it helpful to examine the client's cultural group's history of stigmatization or oppression in the United States. Counselors will have a better understanding of their clients if they are familiar with how a client's cultural group has been affected by the oppression and stigmatization. Of particular interest is how oppression shapes the group response to outsiders and mainstream institutions. People from oppressed groups frequently have difficulty trusting outsiders and institutions, so initial resistance to self-disclosure or seeking outside help may be more a result of group history than avoidance or paranoia. Three case examples illustrate this point.

> Chuck was a 38-year-old Native American who looked very Anglo and had an Anglo name. He had listed his ethnicity as White on the agency intake form. Chuck did not let his counselor know he was a Native American until 3 months later. When the counselor asked why, Chuck replied that it was easier to "just pass." He stated that he'd grown up in Oklahoma near an Indian reservation and that past experience had taught him that "people treat you better if they think you're White." Chuck would often hear people say very negative things about Native Americans, not knowing that he was one himself. He had feared the counselor might be like other people and reject him, so he chose initially to keep his ethnicity a secret.
>
> Althea was a 29-year-old Black woman diagnosed with ARC. A former boyfriend was an IV drug user. Althea stated she was very "upset" with him and worried about her own health. When the intake worker told her it might be a few weeks before a counseling slot opened, she became angry and suspicious and accused the intake worker of not really wanting to help her. When the intake worker explained that they had few counseling staff, that it was difficult for *all* their

clients, and that Althea could call the intake worker if a crisis arose. Althea became calmer and explained that earlier that day, at the bank, a White teller had purposely first served a White person standing behind her in line and that Black people are often "put at the end of the list."

Bobt was a 33-year-old gay man from Thailand diagnosed with AIDS. He was very nervous during his first appointment and refused to say much about himself, but asked the counselor several questions about himself and why and how he chose to work with people with AIDS. Bobt was also very concerned about confidentiality and who would have access to records about him. The counselor answered all his questions openly and honestly and did not push Bobt to talk about himself. As Bobt began to trust the counselor, he began to reveal more about himself. The counselor eventually discovered that Bobt was undocumented. Bobt had heard stories about how undocumented people were reported to immigration by agencies that had promised to help them. In these stories, the undocumented people always ended up being deported. For Bobt, deportation meant certain death because his own country, he said, could not provide any medical treatment for his opportunistic infections.

These three cases illustrate how oppression and stigmatization result in minority clients' distrust of counselors and counseling institutions.

What Are the Client's Traditional Healing Methods?

The client's cultural beliefs about illness, death and dying, and appropriate medical treatment are essential information for a therapist working with people with AIDS from diverse cultures. Some clients may prefer their traditional cultural healing arts to Western medicine. Exploration of these issues may lead to a discussion of the client's spiritual beliefs that may play a key role in the client's coping methods, suicidal risks, and decisions about the use of artificial life support systems. The following two vignettes illustrate the importance of traditional healing methods to clients.

Bart was a 43-year-old Native American diagnosed with AIDS. He was deteriorating rapidly and had lost faith in conventional medical treatment. Bart wanted to see a Native American medicine man whose tribal culture was closest to his own. He stated that he could not be at peace with himself or die with dignity unless he could undergo a tribal purification ceremony to cleanse his spirit and reconnect it to the earth and all living things.

Rafael was a 47-year-old gay Mexican American who had toxoplasmosis. He lived with his 30-year-old Anglo lover. Rafael was depressed because of his diagnosis though physically he felt fine. Individual therapy and reassurances by his physicians did not alleviate his depression. His family in Mexico had found a curandero, or folk healer, and wanted to pay for the healer to live with Rafael and work on him for a month. Though his lover was skeptical, he agreed, and with the support of his AIDS support group members, Rafael told his family to send the healer. Though the healer's practices were unorthodox by Western medical standards, Rafael's belief and participation in her healing rites did alleviate his depression.

These two vignettes illustrate the key role a client's traditional spiritual beliefs play in the client's process of coping with AIDS.

What Are a Particular Culture's Views of Counseling?

The definition of emotional support varies from culture to culture. Culturally sensitive counselors will need to examine a culture's social and familial roles with their AIDS-infected clients. Whether or not the needs of the individual take precedence over the needs of the group will yield information about where a client may seek support, how and when he or she may request it, and what type of support he or she may find acceptable. Clients from some cultures may view counseling as supportive and a way to lessen the burden on friends and family, whereas others may view setting an appointment to discuss highly personal matters with a stranger as bizarre behavior. The following case illustrates this point.

> Calvin was a 32-year-old gay Chinese man diagnosed with AIDS. Because he was unmarried, he lived with his parents and helped care for them. They did not know that he was gay or had AIDS. He told them he had leukemia because he did not want them to feel ashamed of him. Calvin denied any need for counseling though he often felt depressed stating that "counseling was only for real sick or crazy people." However, he would often call or visit the counselor to obtain information and, over time, would begin to discuss some personal feelings. As long as the relationship remained medical, Calvin considered the counselor a "friend at the agency" and could therefore receive supportive therapy without having to take on the stigma of needing counseling.

This example illustrates the impact a client's culture may have on his or her view of the counseling process.

How Does a Culture View the Role of the Therapist?

Clients with AIDS are clearly in the vulnerable position of seeking help. Counselors, therefore, are responsible for making an effort to get to know the client within the client's cultural context. Counselors will often have to develop a more personal relationship with the client. This will help establish trust and alleviate the client's anxiety about the therapist's willingness and ability to transcend cultural differences. A more personal relationship may take the form of a counselor being asked about his or her family, sexual orientation, or motive for doing AIDS work. Counselors may also find themselves in the position of accepting small gifts, making home visits, and even sharing a meal with the client and the client's family. Refusing small gifts or refreshment during home visits would be a rejection of the client's attempt to show appreciation. Such a refusal would seriously alter if not end the relationship. The following example illustrates such a case:

> Maria was a 24-year-old Hispanic woman who was diagnosed with AIDS 6 months after her husband, an IV drug user, had died of AIDS and 2 months after her 3-month-old son was diagnosed with AIDS. She also had two other young children and had recently

moved in with her parents for financial and emotional support. Her parents were supportive but anxious about AIDS transmission. Maria started seeing a counselor shortly after her husband died. Not wanting to overburden her parents and feeling unable to discuss AIDS with her other friends, she was especially grateful for the support counseling provided. When Maria was discharged from the hospital after her second episode of pneumocystis and was too ill to attend to her counseling appointment, the counselor offered to make a home visit. Maria and her family were very pleased. When the counselor arrived, the whole family greeted her, offered refreshment, and insisted she stay for lunch. When the counselor left, they insisted she take the leftovers and thanked her again for all her help. Maria later confided to the counselor that her sharing a meal with the family alleviated their fears about AIDS being transmitted through food and meal sharing.

This example illustrates the need for counselors to transcend cultural differences when doing AIDS work. These cultural differences are examined in the next section.

Issues for Minority Clients At Risk for AIDS

Counselors working with clients at risk for AIDS either in a counseling or in an educative capacity need to be aware of *specific* issues affecting people from diverse cultures in addition to the more *general* considerations discussed above. Admitting that AIDS affects minority communities also means acknowledging the existence of homosexuality, bisexuality, and the use of intravenous drugs. When people are diagnosed with AIDS, they can no longer easily hide their lifestyle or behavior. They must face the stresses that accompany the conflict of determining whether or not to disclose their diagnosis and lifestyle to significant people in their life. In working with minority clients, it is important to examine these issues within the cultural context of each ethnic group. Because the behaviors and attitudes of those infected with HIV via high-risk sexual behavior differ from those infected with the virus via drug use, and the behaviors and attitudes of men differ from those of women, each will be discussed separately. First, it is important to ex-

amine the common ground encompassed in how different cultures view AIDS.

Attitudes Toward AIDS

In his book, *A Strange Virus of Unknown Origin*, Leibowitch (1985) refers to "AIDS a l'Americaine." From his French perspective, Leibowitch writes:

> The AIDS film is an international production on the scale of the media network. But the script is American and carries the cultural insignia of its origin. To tell, to make known, to announce the disease and death—to inform the patient of the medical procedures that will follow, to obtain his [sic] informed consent, to expose and to discuss while exposing . . . North America has its cultural features. The dramatization that results from this relation to discourse, to exposure . . . what sometimes for us, prudish and evasive Latins, assumes the quality of an obscene voyeurism . . . has been, from the start, the trade mark of AIDS a l'Americaine. (p. 93)

Asians and Hispanics, too, view AIDS as a Western or American problem. The small number of Asians in the United States and in Asian countries diagnosed as having AIDS reinforces the belief that AIDS is a Western disease brought on by the high-risk behaviors of Americans and other Westerners. The danger in this belief is the accompanying conviction that if one adheres to Asian cultural norms, there is no need to be concerned about AIDS. The even smaller number of reported AIDS cases among Native Americans leads to a similar denial of AIDS as being a problem with which that population needs to concern itself. Although many Hispanics have heard about AIDS, they may have little information other than "it's a sleazy disease" (Jue, 1988). Sexual behavior is not a socially acceptable topic of conversation among most Asians, Hispanics, and Native Americans, and uncomfortable feelings surface when the transmission of AIDS is discussed.

The belief that AIDS originated in Africa and the inclusion by the Centers for Disease Control of Haitians as a separate high-risk group up until 1986 has adversely affected the Black community. Many Blacks feel there is an underlying message

that there may be something intrinsic to Blacks that makes them responsible for the origin and spread of the disease. Thus, the Black community struggles with anger, resentment, suspiciousness, and even defensiveness about AIDS while trying to care for the 24% of all AIDS cases that are Black (Centers for Disease Control, 1986).

Issues for Minority Gay and Bisexual Men

Because many men are hidden in their communities where extremely strong taboos against homosexuality exist, there is little information on Asian, Hispanic, Native American, or Black gays and bisexuals. Most of these ethnic cultures consider homosexuals to be men trying to be women or men engaging in isolated sexual behaviors that they can chose to do or not to do. Homosexuality is often viewed as perverted and obscene, a disease to be cured, or a sin against God and nature. Nearly all minority clients voice feelings of isolation. The absence of a supportive environment and the low visibility of minority gay people has helped perpetuate the perception that homosexuality is a White American phenomenon. Gay organizations in minority communities are rare, and those attending to people with AIDS even rarer, leaving minority gays to join the White gay community or remain isolated in their own community.

Because of the oppression of homosexuals in ethnic cultures, many men may engage in same-sex behavior and may choose to continue to define themselves as heterosexual. Peterson and Mann (1988) reported that many authors suggest that men who have sex with other men may not label themselves as homosexual depending upon the meaning of or reasons for the sexual behavior. Men may engage in same-sex behavior for recreational reasons related to physical pleasure, or for economic reasons (i.e., prostitution). They may participate in only "masculine" roles, being the insertor in oral and anal sex. In each of these cases, the man may participate without compromising his self-identified heterosexual orientation.

This lack of a large and viable gay minority community with which to identify and the difficulty minority men have in assuming a personal gay or bisexual identity result in a situation of severe isolation—not only from AIDS care but also from AIDS education. Whereas White gay men receive AIDS education information through gay newspapers, gay bars, and gay

organizations, this information will not be available to most ethnic minority gay men. In addition, many of the current AIDS information pamphlets are written in English and at a high school educational level, thereby excluding non-English speaking minorities and those men without higher education. All these factors put minority gay and bisexual men at higher risk.

Of extreme concern to counselors and educators doing prevention and education work are the many erroneous beliefs regarding AIDS some minority gay men hold. One common, incorrect belief is that anal intercourse is safe if one is the active rather than the receptive partner. Another erroneous belief is that high-risk sexual activities are safe if one engages in those activities only with minority rather than with White men (Peterson & Marin, 1988). Part of the acceptance of these erroneous beliefs may be due to lack of education. In a Black community survey in Detroit, Williams (1986) found that Black gay men were less informed about the AIDS epidemic than Black IV drug users, and were unable to correctly identify the modes of transmission of HIV (Peterson & Marin). Peterson and Marin suggested street outreach campaigns employing minority men knowledgeable about AIDS risk reduction and familiar with the sociosexual contexts of ethnic minority communities as a means of combating this isolation and lack of information.

Issues for Minority IV Drug Users

About 85% of all people who contracted AIDS from using intravenous drugs have been from minority groups, primarily Black and Hispanic (Centers for Disease Control, 1986, June 30). Drug users who are poor are more likely than are affluent abusers to share needles or frequent shooting galleries, because needles are difficult to obtain.

Alcohol and nonintravenous drugs contribute indirectly to the spread of AIDS. When one is under the influence of such substances, one's judgment is impaired and the likelihood of engaging in unsafe sex increases. With sexually ambivalent men, drugs may be a way of overcoming inhibitions and later disclaiming responsibility for the behavior. Joe (1987) described a client who stated that he had sex with men only when he was high because he could not handle it any other way. Because of the added stress involved in being gay or bisexual and the prev-

absence of drugs in some minority communities, minority people are at a greater risk of contracting AIDS from a combination of drug use and sexual behavior.

There is a need to develop appropriate AIDS prevention and education programs in drug treatment clinics in minority communities (Peterson & Mann, 1988). Counselors will need to educate IV drug users about the risks of AIDS either before they are infected or before they infect their partners. Trandis, Mann, Fisansky, and Betancourt (1988) recommended that the programs include ethnic minority staff who would be more accepted by minority addicts because of their knowledge of the minority cultural values, particularly social scripts related to respect and positive social relations. Because IV drug users not in treatment outnumber those in treatment, prevention and education programs are also needed on a "street" level.

Issues for HIV-infected Wives and Sexual Partners

For those men who are more dependent on or emotionally tied to their ethnic community, bisexuality is an alternative to being gay. The fear of exposing their double lives often causes these men to have multiple anonymous sexual encounters outside of their communities. Because these men are most likely to deny the gay or bisexual label or to admit they have had sex with men, their wives have no idea of their extramarital affairs or their risk for AIDS. Many wives may not know about their husbands' same-sex behavior until the devastating time that he or she herself is diagnosed with AIDS.

The wives of bisexual men with AIDS experience anger, betrayal, loss of trust, and fear for their health and that of their young children who may have been conceived while the father was infectious. They may also feel inadequate and ashamed, considering themselves failures as wives and as female sexual partners. Under normal circumstances these women would turn to their families and friends for support. The stigma attached to AIDS and their own sense of shame, whether or not they might also be diagnosed with AIDS, leaves them isolated. The women shoulder the burden of keeping the truth to themselves in addition to caring for their spouses and families with little or no support. This is particularly true if the woman is monolingual. The tragedy is compounded if the woman herself is also diagnosed with AIDS.

IV drug use among minority men indirectly accounts for a large number of minority female cases of AIDS as a result of sexual contact. Female partners of IV drug users are likely to be part of a secondary epidemic of heterosexually transmitted AIDS cases, especially among Blacks and Hispanics (Peterson & Marin, 1988). Many sexual partners of IV drug users may not realize that they are at risk for HIV infection because IV drug users do not usually disclose their serostatus to their partners out of a fear of rejection and lack of emotional support.

A significant problem for minority women is the lack of information not only about AIDS but about birth control as well. For traditional Hispanic or Latino women in particular, cultural pressures swing toward female naivete (Mays & Cochran, 1988); this also holds true for Asian Pacific and Native American women. Because being prepared means that one has considered having sexual relations, which is something only "bad" girls do, those women who have access to birth control devices do not always use them.

AIDS education and prevention programs often advocate that women discuss sexual practices and condom use with their sexual partners. This suggestion fails to take into account cultural norms concerning sexual behavior. Mays and Cochran (1988) reported that although AIDS risk reduction messages advocate female initiation of condom use, among traditional Latin cultures authorization for use of contraceptives lies with the husband. They also describe a small subset of Black and Latino women who experience physical and verbal abuse in response to requests that their partners use condoms. In addition, some Black women, particularly those at higher risk for AIDS, have yet to incorporate effective birth control methods into their sexual behavior repertoires in the first place (Mays & Cochran). In many Asian Pacific cultures, condoms are associated with prostitution, so condom use with a spouse or nonprostitute would be an insulting gesture. Peterson and Marin (1988) also mentioned a woman's emotional or economic dependence on a male partner as prohibitive to the adoption of safer sex practices.

Cultural issues also play a role in a woman's decision-making process if she does become pregnant. Many minority women do not believe in abortion for cultural or religious reasons. Thus, if they become pregnant, minority women with AIDS are likely to give birth to children who will eventually develop AIDS.

Implications for Counselors

Many obstacles prevent people with AIDS from seeking professional help. These obstacles are magnified when the person with AIDS is from an ethnic minority group. Often minority clients do not know what counselors do or what counseling is and do not think it makes sense to pay someone to listen to them talk about their problems. They are more familiar with the medical model in which physicians prescribe medication for symptoms. Asians and Hispanics, who have a greater tendency to somatize problems than do Blacks, find it especially difficult to differentiate between somatic complaints and the symptoms of AIDS-related infections (Acosta, Yamamoto, & Evans, 1982).

Rather than hearing a description of what counseling is, clients will find it more useful if the counselor explains how he or she can be of assistance. Minority clients prefer a concrete, directive, problem-solving approach with immediate results (McGoldrick, Pearce, & Giordano, 1982). Minority clients' initial needs include information and referral, advocacy, and assistance in obtaining benefits and concrete services rather than discussion of feelings and life history. Following through on concrete tasks will reinforce the clients' perception that the counselor understands their needs and can be helpful. Afterwards, clients will be more receptive to sharing personal feelings.

Because many clients with AIDS believe they cannot go to their families for help, they are forced to seek assistance elsewhere. For many, it is the first time they have had to negotiate systems outside their communities. If they speak little or no English, the task can be overwhelming. The following suggestions reflect only a few of the issues and influences with which a culturally sensitive counselor doing AIDS work must contend.

1. Counselors working with minority clients will need to build trust. Often minority clients are unsure of how well counselors from different ethnic backgrounds will understand them. This is particularly true when they have difficulties expressing themselves in English. Minority clients perceive the White gay community as having the most knowledge about and resources to cope with AIDS, but are unsure if that community will accept and support them.

Jue (1987) interviewed minority AIDS clients at a large metropolitan AIDS service agency. These clients reported that

to build trust they needed to feel that the counselor cared about them as individuals and that the relationship was personal and not strictly business. What White counselors may view as unprofessional self-disclosures or useless chitchat minority clients may view as an important way to develop a personal relationship. This sharing of information equalizes the power differential in the relationship and enables the client to decide whether he or she can trust the counselor to understand his or her different needs. When clients are undocumented residents, trust is even more important because of their fear of deportation to countries in which medical care for AIDS patients is often inadequate or unavailable and the social climate is less accepting.

2. Counselors working with minority clients must assure clients that their work together is confidential. Some minority clients may be living with parents or have parents visiting who may know the diagnosis but not the high-risk behaviors involved. During work with the family, it is important for the counselor to clarify with the client what he or she wishes others to know. Minority clients also may want to know about confidentiality and record-keeping policies because of involvement with illicit drugs or because of precarious immigration status.

3. Counselors working with minority clients must maintain consistency between their actions, nonverbal behavior, and what they say to clients. For all minority clients, actions speak louder than words, so following through on promises made and displaying behaviors consistent with opinions counselors have verbalized to clients is paramount to establishing trust.

4. Counselors must be prepared to work with a minority client's family or with client-family concerns. Families play a huge role in the lives of minority clients. Whether or when to tell the family about the AIDS diagnosis and high-risk behaviors is a major issue for clients, complicated by the fact that many minority clients live with their parents and take care of them. Thus, clients are not only afraid of being rejected but are concerned about who will provide for the parents if they are disowned or die. Many clients have relied on their families for support throughout their lives and may not have a reliable alternate support system, so they have more to lose than many other clients if they are rejected. It may take months for clients to decide how to disclose their situation to their families, and the decision is often influenced by the state of their health.

Because it is unacceptable for Asian and Hispanic families to reject an ill child, clients of these groups sometimes decide

to tell their families about their diagnosis when they are so ill they can barely care for themselves. Although the families respond by providing care and shelter, they are not always able to provide emotional support. Therefore, when working with families, the counselor may find it helpful to minimize the stigma of AIDS. In addition, in families in which role expectations are a sign of caring, counselors can focus on how well the client and his or her family have fulfilled their obligations in the past and how they can continue to support each other as these roles change.

Whereas Asians tend to immigrate in families, many Hispanics do not. Those with families outside the United States usually do not tell their parents about their diagnosis unless their families already know they are gay. Many of their families cannot afford to visit them, so alternate support systems in the United States are essential. During the end stages of AIDS, most of these clients prefer to go home so they are with their families when they die. At this point, one's life style and diagnosis are irrelevant, and there is no need to seek medical treatment or to fear rejection.

Poe (1987) described several Black clients who felt they would go to their families only as a last resort. Many adult Black clients think they should be responsible for themselves and not have to depend on their parents. For Native Americans with family living on reservations, returning home would not be a viable alternative; health care available on reservations is poor in general, and virtually nonexistent for AIDS-related illnesses. Blacks and Native Americans, because of similar histories of cultural genocide in the United States, have more reason to deny new problems like AIDS that carry a stigma.

5. Counselors working with minority clients should be prepared to use a translator when necessary. With a subject as emotionally charged as AIDS and its associated high-risk behaviors, it is imperative to find a translator who can remain objective, supportive, and culturally sensitive. The translator must maintain strict confidentiality especially if he or she lives in the same ethnic community as the client. It is also important to evaluate the translator's knowledge and feelings about AIDS; someone who is frightened or judgmental will not be able to translate accurately. The use of a younger child as a translator is inappropriate because it both burdens the child and undermines parental authority. The counselor should discuss his or her expectations with the translator before seeing the client.

together. A good translator can also be an excellent resource for learning more about a client's culture.

6. Counselors working with minority clients will need to evaluate their clients' level of acculturation. Whenever a counselor works with clients from another culture, it is essential that he or she evaluate their clients' education, socioeconomic level, command of the English language, and level of acculturation. Because family members adapt in different ways and to varying degrees, counselors may need to alter their approach from client to client and from family member to family member. Differences in acculturation often lead to family conflicts, which can become more pronounced when a member is diagnosed as having AIDS. Clients who are rooted in their ethnic community experience feelings of anxiety and a sense of loss when they leave their secure environment to seek help in an unfamiliar culture that may be unsupportive. The culturally sensitive counselor often becomes the cornerstone of an alternate support system for these clients.

7. Counselors will need to modify their preferred treatment modality to allow for cultural differences. Clients cannot be taken out of the context of their ethnic background, community, or sexual life style. A systems and problem-solving approach is effective, as is counseling that is directive, supportive, and short-term. Group work can be effective if members are carefully screened for their level of acculturation, fluency in a common language, and willingness to participate. The group leader should be directive and focused, and set a tone in which members do not feel overly pressured to reveal themselves or fearful of losing face. A more structured educational focus is useful initially because it provides a concrete service and an opportunity for group members to get to know each other in a less threatening manner.

8. Counselors working with minority clients will have to confront formidable countertransference issues. Working with minority clients forces counselors to confront their feelings about AIDS, death and dying, ethnic minority groups, gay and bisexual people, substance abuse, family issues, unwed mothers, abortion, racism, and poverty. Underlying all of these issues are the counselors' basic cultural and individual values. As clients struggle to redefine themselves and their lives post-HIV infection, counselors in a somewhat parallel process are forced to reevaluate how their own cultural and personal biases influence their perception of clients from other cultures. In many cases,

counselors will need to confront their tendency to view those who are different as inferior or undesirable. This may be manifested in many ways: counselors refusing to work with certain clients because they do not want to make the effort to understand, or counselors minimizing the validity and importance of cultural differences or attempting to impose their own cultural values on the client. Other common dilemmas in working with HIV-infected clients are the tendencies for counselors to overidentify with clients because so many are about the same age, and to become overly involved with clients because their needs are so numerous and resources are so limited. Both situations lead rapidly to burnout.

Conclusion

To preserve their cultural integrity and to ensure their survival, minority communities exert strong pressures on their members to conform to group norms. Because high-risk behaviors associated with HIV infection tend to be denigrated by all cultures, most cultures adopt a blame-the-victim attitude toward people with AIDS. The challenge for counselors is to help clients maintain a sense of cultural pride and integrity without taking on the negative cultural judgments attached to their high-risk behaviors.

Another challenge to counselors will be to expand their concept of what therapy is and how it works in order to accommodate clients who are not acquainted with psychotherapy. Counselors need not cast aside their existing expertise as much as integrate concepts from their own and their clients' cultures into a mutually satisfying therapeutic relationship. Once counselors are able to validate cultural differences, they must then seek the values common to all cultures in order to make a meaningful connection to their clients.

Counselors will be further challenged to take more responsibility for developing culturally appropriate interventions and services to minority clients. This is true not only on an individual basis but also on an agency level. Networking and coalition building enable minority and AIDS agencies to share expertise and learn from one other. Working together is more cost-effective and efficient and provides agencies with an opportunity to expand their perspectives and to overcome ethnic divisions and hostilities.

As the AIDS epidemic continues to infect communities already afflicted by prejudice, poverty, and a scarcity of opportunities, it becomes increasingly important for counselors to address the needs of ethnic minority clients. Each counselor must find his or her own way to face the challenges of becoming more culturally sensitive to the issues that confront minority people with AIDS. Counselors and clients alike must be made aware that without knowledge and understanding *anyone* can become HIV-infected. Because the HIV virus does not discriminate, counselors cannot afford to either.

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